

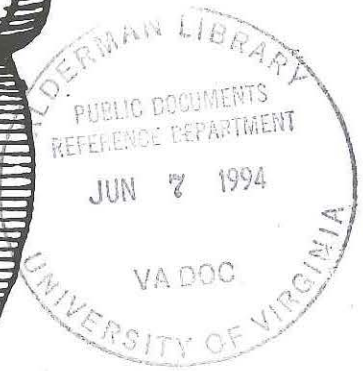
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THE VIRGINIA REGISTER

OF REGULATIONS

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May 30, 1994

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VIRGINIA REGISTER

The *Virginia Register* is an official state publication issued every other week throughout the year. Indexes are published quarterly, and the last index of the year is cumulative.

The *Virginia Register* has several functions. The full text of all regulations, both as proposed and as finally adopted or changed by amendment are required by law to be published in the *Virginia Register of Regulations*.

In addition, the *Virginia Register* is a source of other information about state government, including all Emergency Regulations issued by the Governor, and Executive Orders, the *Virginia Tax Bulletin* issued periodically by the Department of Taxation, and notices of all public hearings and open meetings of state agencies.

ADOPTION, AMENDMENT, AND REPEAL OF REGULATIONS

An agency wishing to adopt, amend, or repeal regulations must first publish in the *Virginia Register* a notice of proposed action; a basis, purpose, impact and summary statement; a notice giving the public an opportunity to comment on the proposal, and the text of the proposed regulations.

Under the provisions of the Administrative Process Act, the Registrar has the right to publish a summary, rather than the full text, of a regulation which is considered to be too lengthy. In such case, the full text of the regulation will be available for public inspection at the office of the Registrar and at the office of the promulgating agency.

Following publication of the proposal in the *Virginia Register*, sixty days must elapse before the agency may take action on the proposal.

During this time, the Governor and the General Assembly will review the proposed regulations. The Governor will transmit his comments on the regulations to the Registrar and the agency and such comments will be published in the *Virginia Register*.

Upon receipt of the Governor's comment on a proposed regulation, the agency (i) may adopt the proposed regulation, if the Governor has no objection to the regulation; (ii) may modify and adopt the proposed regulation after considering and incorporating the Governor's suggestions, or (iii) may adopt the regulation without changes despite the Governor's recommendations for change.

The appropriate standing committee of each branch of the General Assembly may meet during the promulgation or final adoption process and file an objection with the *Virginia Registrar* and the promulgating agency. The objection will be published in the *Virginia Register*. Within twenty-one days after receipt by the agency of a legislative objection, the agency shall file a response with the Registrar, the objecting legislative Committee, and the Governor.

When final action is taken, the promulgating agency must again publish the text of the regulation, as adopted, highlighting and explaining any substantial changes in the final regulation. A thirty-day final adoption period will commence upon publication in the *Virginia Register*.

The Governor will review the final regulation during this time and if he objects, forward his objection to the Registrar and the agency. His objection will be published in the *Virginia Register*. If the Governor finds that changes made to the proposed regulation are substantial, he may suspend the regulatory process for thirty days and require the agency to solicit additional public comment on the substantial changes.

A regulation becomes effective at the conclusion of this thirty-day final adoption period, or at any other later date specified by the promulgating agency, unless (i) a legislative objection has been filed, in which event the regulation, unless withdrawn, becomes effective on the date specified, which shall

be after the expiration of the twenty-one day extension period; or (ii) the Governor exercises his authority to suspend the regulatory process for solicitation of additional public comment, in which event the regulation, unless withdrawn, becomes effective on the date specified which date shall be after the expiration of the period for which the Governor has suspended the regulatory process.

Proposed action on regulations may be withdrawn by the promulgating agency at any time before the regulation becomes final.

EMERGENCY REGULATIONS

If an agency determines that an emergency situation exists, it then requests the Governor to issue an emergency regulation. The emergency regulation becomes operative upon its adoption and filing with the Registrar of Regulations, unless a later date is specified. Emergency regulations are limited in time and cannot exceed a twelve-months duration. The emergency regulations will be published as quickly as possible in the *Virginia Register*.

During the time the emergency status is in effect, the agency may proceed with the adoption of permanent regulations through the usual procedures (See "Adoption, Amendment, and Repeal of Regulations," above). If the agency does not choose to adopt the regulations, the emergency status ends when the prescribed time limit expires.

STATEMENT

The foregoing constitutes a generalized statement of the procedures to be followed. For specific statutory language, it is suggested that Article 2 of Chapter 1.1:1 (§§ 9-6.14:6 through 9-6.14:9) of the Code of Virginia be examined carefully.

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Symbol Key †

† Indicates entries since last publication of the Virginia Register

DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES (BOARD OF)

Notice of Intended Regulatory Action

AMENDED NOTICE

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Agriculture and Consumer Services intends to consider amending regulations entitled: **VR 115-02-02. Rules and Regulations Governing the Prevention, Control, and Eradication of Bovine Tuberculosis in Virginia.** The purpose of the proposed regulation is to review the regulation for effectiveness and continued need, including but not limited to: (i) adding provisions to require testing and subjecting to other requirements within the regulation of (a) all classes of bovidae (not just cattle), (b) all cervidae (many of the deer), and (c) all capridae (goats); (ii) considering alternative ways of disposing of tuberculosis-infected animals; (iii) a proposal to shorten the time in which a report must be made to the State Veterinarian when tuberculosis is suspected; (iv) requiring owners of cervidae to maintain records for three years to include: (a) owners name and address, (b) individual identification of each animal to include species, (c) name and address of where the animal was purchased, (d) date of purchase, (e) date and to whom the animal was sold, and (f) date and results of any official tests performed; and (v) requiring dealers in livestock/exotic species to register with the State Veterinarian's office.

The agency invites comment on whether there should be an advisor appointed for the present regulatory action. An advisor is: (i) a standing advisory panel; (ii) an ad-hoc advisory panel; (iii) consultation with groups, (iv) consultation with individuals; or (v) any combination thereof.

The agency plans to hold a public hearing on the proposed regulation after it is published.

Statutory Authority: §§ 3.1-724, 3.1-726, and 3.1-730 of the Code of Virginia.

Written comments may be submitted until 8:30 a.m. on June 6, 1994, to Dr. W.M. Sims, Jr., VDACS, Division of Animal Health, P. O. Box 1163, Richmond, VA 23209-1163.

Contact: T.R. Lee, Program Supervisor, Department of Agriculture and Consumer Services, 1100 Bank Street, P. O. Box 1163, Richmond, VA 23209-1163, telephone (804) 786-2483.

VA.R. Doc. No. R94-831; Filed April 12, 1994, 3:06 p.m.

Notice of Intended Regulatory Action

AMENDED NOTICE

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Agriculture and Consumer Services intends to consider amending regulations entitled: **VR 115-02-12. Rules and Regulations Pertaining to the Health Requirements Governing the Admission of Livestock, Poultry, Companion Animals, and Other Animals or Birds into Virginia.** The purpose of the proposed regulation is to review the regulation for effectiveness and continued need, including but not limited to: (i) adding provisions governing the importation of cervidae—most varieties of deer; (ii) repealing provisions requiring a permit for the importation of psittacine (parrot-like) birds and repealing provisions requiring that they be treated for psittacosis; (iii) repealing provisions requiring South American camelids of the genus *Lama* to be tested for bluetongue; (iv) requiring rabies vaccination for cats entering the Commonwealth; (v) adding importation requirements for bison, to treat them more consistently with cattle; and (vi) relaxing certain requirements pertaining to feeder cattle.

The agency invites comment on whether there should be an advisor appointed for the present regulatory action. An advisor is: (i) a standing advisory panel; (ii) an ad-hoc advisory panel; (iii) consultation with individuals; or (v) any combination thereof.

The agency plans to hold a public hearing on the proposed regulation after it is published.

Statutory Authority: §§ 3.1-724, 3.1-726, and 3.1-730 of the Code of Virginia.

Written comments may be submitted until 8:30 a.m. on June 6, 1994, to Dr. W.M. Sims, Jr., VDACS, Division of Animal Health, P. O. Box 1163, Richmond, VA 23209-1163.

Contact: T.R. Lee, Program Supervisor, Department of Agriculture and Consumer Services, 1100 Bank Street, P. O. Box 1165, Richmond, VA 23209-1163, telephone (804) 786-2483.

VA.R. Doc. No. R94-832; Filed April 12, 1994, 3:06 p.m.

Notices of Intended Regulatory Action

STATE AIR POLLUTION CONTROL BOARD

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Air Pollution Control Board intends to consider amending regulations entitled: **VR 120-01. Regulations for the Control and Abatement of Air Pollution: Open Burning (Rev. FF)** The purpose of the proposed action is to develop regulations which will allow the state to reduce volatile organic compounds (VOC) emissions. Under the federal Clean Air Act (Act), Virginia must reduce these emissions by 15% from the 1990 base year level emissions. This must be done by the end of 1996. The secondary purpose of the proposed action is to provide the administrative mechanism for local governments to assume responsibility for developing and enforcing restrictions on open burning.

Public Meeting: A public meeting will be held by the department in the Board Room, Department of Environmental Quality Office Building, 4900 Cox Road, Innsbrook Corporate Center, Glen Allen, Virginia, at 5 p.m. on June 30, 1994, to discuss the intended action. Unlike a public hearing, which is intended only to receive testimony, this meeting is being held to discuss and exchange ideas and information relative to regulation development.

Accessibility to Persons with Disabilities: The meeting is being held at a public facility believed to be accessible to persons with disabilities. Any person with questions on the accessibility of the facility should contact Ms. Doneva Dalton at the Office of Regulatory Services, Department of Environmental Quality, P.O. Box 10009, Richmond, Virginia 23240, or by telephone at (804) 762-4379 or TDD (804) 762-4021. Persons needing interpreter services for the deaf must notify Ms. Dalton no later than June 23, 1994.

Ad Hoc Advisory Group: The department is soliciting comments on the advisability of forming an ad hoc advisory group, using a standing advisory committee, or consulting with groups or individuals registering interest in working with the department to assist in the drafting and formation of any proposal. Any comments relative to this issue must be submitted in accordance with the procedures described under the "Request for Comments" section above.

Public Hearing Plans: After publication in The Virginia Register of Regulations, the department will hold at least one public hearing to provide opportunity for public comment on any regulation amendments drafted pursuant to this notice.

Need: One of the primary goals of the federal Clean Air Act (Act) is the attainment and maintenance of the National Ambient Air Quality Standards (NAAQS). These standards, designed to protect public health and welfare, apply to six pollutants, of which ozone is the primary focus of this proposed action. Ozone is formed when

volatile organic compounds (VOCs) and nitrogen oxides (NOX) in the air react together in the presence of sunlight. VOCs are chemicals contained in gasoline, polishes, paints, varnishes, cleaning fluids, inks, and other household and industrial products. NOX emissions are a byproduct from the combustion of fuels and industrial processes.

The National Ambient Air Quality Standard for ozone is 0.12 parts per million (ppm) and was established by the U.S. Environmental Protection Agency (EPA) to protect the health of the general public with an adequate margin of safety. When concentrations of ozone in the ambient air exceed the federal standard the area is considered to be out of compliance and is classified as "nonattainment." Numerous counties and cities within the Northern Virginia, Richmond, and Hampton Roads areas have been identified as ozone nonattainment areas according to new provisions of the Act.

Virginia is required by the Act to develop plans to ensure that areas will come into compliance with the federal ozone ambient air quality standard. Failure to develop adequate programs to meet the ozone air quality standard (i) will result in continued violations of the standard; (ii) may result in assumption of the program by EPA, at which time the Commonwealth would lose authority over matters affecting its citizens; and (iii) may result in the implementation of sanctions by EPA, such as more restrictive requirements on new major industrial facilities and loss of federal funds for highway construction. Furthermore, if a particular area fails to attain the federal standard by the legislatively mandated attainment date, EPA is required to reassign it to the next higher classification level (denoting a worse air quality problem), thus subjecting the area to more stringent air pollution control requirements.

The Act requires that regional transportation plans and individual highway projects conform with Virginia's air quality plan. Conformity of transportation plans means that emissions from mobile sources must remain within the emissions budget established in the plan. Conformity determinations must be made when Virginia applies for federal highway funds. In order to make conformity determinations, EPA requires Virginia to submit a plan with an emissions budget and enforceable control measures for implementation of the plan. Once EPA has determined that the plan is complete, aside from the enforceable control measures, Virginia can continue to make conformity determinations provided the enforceable control measures (regulations) are submitted to EPA within one year of the EPA's completeness determination.

A. Northern Virginia Area

The metropolitan Washington area has been designated as a serious nonattainment area under the Act. Consequently, its attainment date is November 15, 1999.

The Act specifies that a plan be developed to ensure

Notices of Intended Regulatory Action

that VOC emissions in the area are reduced by 15% by the end of 1996. About half of the VOCs in the area are emitted from cars, trucks, and buses; the other half are emitted from small sources like printing shops, service stations, auto body shops, and people using gasoline-powered equipment, paints, solvents, etc. (Large industrial facilities like power plants and factories emit only about 4.0% of the VOCs in this area.)

The task of assessing the various control options, selecting those control measures which will result in the 15% VOC reductions, and preparing the plan has been assigned by the three states comprising the Metropolitan Washington Area to the Metropolitan Washington Air Quality Committee (MWAQC). MWAQC consists of elected officials from the affected localities and representatives of state transportation and air quality planning agencies from Virginia, Maryland, and the District of Columbia. However, the final decision on the 15% emissions reduction plan and submission to EPA rests with each state.

MWAQC has recommended that Maryland, Virginia, and the District of Columbia submit to EPA a plan that includes a number of control measures to provide emission reduction credits required to achieve the 15% VOC emission reduction target. These control measures will require each jurisdiction to amend emissions standards for certain categories of currently regulated VOC sources and create new standards for other uncontrolled sources. These new and revised emissions standards will result in the reduction of VOC emissions as identified in the MWAQC's 15% emissions reduction plan.

Open burning is among the many source types from which VOC emissions reductions have been identified in MWAQC's 15% emissions reduction plan. The total reduction target for the metropolitan Washington area is 133 tons per day of VOC emissions, of which 60 tons must come from the Northern Virginia Nonattainment Area. Of these 60 tons, 2.6 tons must come from open burning. The control of the emissions from open burning, along with other control measures recommended in the MWAQC plan, will provide the 15% reduction in VOC emissions required by the plan.

In addition, the MWAQC plan also establishes the initial emissions budget for point (large stationary), area (small stationary) and mobile sources. This is done by projecting the 1996 emissions as a 15% reduction from the 1990 baseline emissions. In order to make an acceptable conformity determination, Virginia transportation planning organizations must demonstrate that the mobile source emissions will remain within the mobile source portion of the 1996 emissions budget.

On November 15, 1993, Virginia submitted the draft MWAQC plan for EPA review. On January 20, 1994, EPA determined that the plan was complete except for the enforceable control measures which must be submitted as regulations within one year of EPA's completeness determination. In order for Virginia to continue making

conformity determinations for highway projects, regulations covering the sources listed above must be submitted to EPA by January 20, 1995.

B. Richmond Area

The Richmond area has been designated as a moderate nonattainment area under the Act. As such, the Act specifies that the area must reduce its emissions of VOCs by 15% by November 15, 1996.

The Act requires that Virginia adopt regulations for sources for which EPA has issued a control technology guideline (CTG) between the time of enactment of the 1990 Amendments to the Act and the attainment date for the nonattainment area. This requirement pertains to moderate or worse nonattainment areas. A CTG defines what is considered to be reasonably available control technology (RACT) for a specific source category. RACT is the lowest emission limit that a particular source is capable of meeting by the application of control technology that is reasonably available considering technological and economic feasibility. Since the time of enactment, EPA has published CTGs for several categories of sources. A review of existing sources in the Richmond Nonattainment Area identified several sources in the CTG source categories of industrial waste water operations and synthetic chemical and polymer manufacturing equipment prone to VOC leaks. Consequently, Virginia must develop regulations for these two source types by November 15, 1994.

The Act also provides a process for a state to petition EPA to officially redesignate a nonattainment area to attainment. The Act stipulates that for an area to be redesignated, EPA must fully approve a maintenance plan. A state may submit both the redesignation request and the maintenance plan at the same time, and the EPA review and approval process for both may proceed on a parallel track. The lack of ozone standard violations in the most recent three-year period prior to the redesignation request being approved by EPA, is another condition that must be met before the area can be redesignated. An area is determined to be in violation of the ozone air quality standard if the three-year average of exceedances at any of the area's monitors is greater than one.

A redesignation request for the Richmond Nonattainment Area was submitted to EPA on November 12, 1992. The Commonwealth was able to meet all of the criteria necessary for requesting redesignation, including the lack of ozone violations during the three-year period between 1990 and 1992. In addition, Virginia submitted a maintenance plan demonstrating that, because of permanent and enforceable measures, emissions over the ten years following redesignation would remain within the standards while allowing for growth in population and vehicle miles traveled.

On August 17, 1993, EPA proposed approval of the request and maintenance plan in the Federal Register.

Notices of Intended Regulatory Action

Subsequently, EPA withdrew its original proposed approval and on May 3, 1994, issued a final notice of disapproval. This was because of a number of exceedances of the ozone standard recorded at Richmond area ozone monitors during the summer of 1993, which caused the three-year average of exceedances at one of the Richmond area monitors during 1991, 1992 and 1993 to exceed one. In other words, the air quality in the Richmond area had violated (was not attaining) the ozone standard.

Virginia is now obligated to develop a plan to institute control measures to reduce emissions of VOCs in the area by 15% by the end of 1996. The plan is currently being developed and may call for new regulatory requirements on any of the source types listed in this notice. If this is the case, pertinent regulations will be promulgated to amend existing emissions standards and create emission standards for sources currently unregulated so that the necessary 15% reduction of VOC emissions will be achieved.

C. Hampton Roads Area

The Hampton Roads area has been designated as a marginal nonattainment area under the Act, and its attainment date was November 15, 1993. As such, the Act specifies that certain deficiencies in the regulatory program in place at the time of the Act's reauthorization in 1990 be corrected to bring it in line with EPA policy.

The Act provides a process whereby EPA must determine whether or not a nonattainment area achieves the air quality standard by the attainment date. Within six months after the attainment date for each nonattainment area, EPA must determine whether the area has attained the ozone standard. This is accomplished by reviewing the state's quality-assured air quality data from the previous three-year period. An area is determined to be in violation of the ozone air quality standard if the three-year average of exceedances at any monitor is greater than one. The Hampton Roads area would achieve attainment status as long as the ozone standard of 0.12 ppm was not exceeded on more than three days at any one ozone monitor in the Hampton Roads area during 1991, 1992, and 1993.

Recent air quality data shows, however, that the Hampton Roads area may not have achieved the standard by the required attainment date. If EPA determines that an ozone air quality standard violation has occurred, it must change the area's nonattainment status from marginal to moderate. If the area's status is changed, it is not clear, at this time, which of the control strategies required in moderate nonattainment areas will be mandated for affected sources in the Hampton Roads area. It is possible that Virginia may be obligated to develop a plan to institute control measures to reduce emissions of VOCs in the area, as was required for the Northern Virginia and Richmond areas. Once completed, the plan may call for new regulatory requirements applying to any of the source types listed in this notice. Consequently, pertinent regulations will be promulgated to amend existing

emissions standards and create emission standards for sources currently unregulated in order to achieve the necessary reduction of VOC emissions.

In addition, the Governor's Commission on Efficiency in Government has recommended that the responsibility for regulating open burning be transferred from state government to local governments. Not only would local control be more cost effective than state control, it would encourage cities and counties to develop enforcement programs tailored to their individual needs, which vary widely across the state depending on each jurisdiction's population distribution, geography, industry, and other factors.

Alternatives:

1. Draft regulations which will provide for implementation of the plans to reduce VOC emissions from the 1990 base year level by 15% by the end of 1996 in order to make progress toward the attainment of the ozone air quality standard in the nonattainment areas and which meet the provisions of the federal Clean Air Act and associated EPA regulations and policies.

2. Make alternative regulatory changes to those required by the 15% emissions reduction plans, thus jeopardizing Virginia's achievement of its required total reduction target. The sanctions for such a failure are the same as those listed below in Alternative 3.

3. Take no action to amend the regulations and assume the associated risks. If Virginia fails to submit the regulations by January 20, 1995, for achieving the reductions required by the 15% plan, Virginia will no longer be able to make conformity determinations and will not be able to apply for federal highway funds. Another consequence of failure to implement the 15% emissions reduction plan would be the imposition of sanctions by EPA. These may include withholding federal highway funds or air quality planning grants, requiring new industries to offset emissions to such a degree that economic growth may be hindered, or imposing a federal plan on the state. Furthermore, if a nonattainment area fails to attain the federal standard for ozone by its attainment date, EPA must reassign it to the next higher classification level (denoting a worse air quality problem), thus subjecting the area to more stringent control requirements.

Costs and benefits: The department is soliciting comments on the costs and benefits of the alternatives stated above or other alternatives.

Applicable federal requirements: The 1990 Amendments to the Clean Air Act (new Act) represent the most comprehensive piece of clean air legislation ever enacted to address air quality planning requirements for areas that had not attained the federal air quality standard for ozone (that is, nonattainment areas). The new Act established a

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process for evaluating the air quality in each region and identifying and classifying each nonattainment area according to the severity of its air pollution problem. Nonattainment areas are classified as marginal, moderate, serious, severe and extreme. Marginal areas are subject to the least stringent requirements and each subsequent classification (or class) is subject to successively more stringent control measures. Areas in a higher classification of nonattainment must meet the mandates of the lower classifications plus the more stringent requirements of its own class. Virginia's ozone nonattainment areas are classified as marginal for the Hampton Roads Nonattainment Area, moderate for the Richmond Nonattainment Area, and serious for the Northern Virginia Nonattainment Area.

Once the nonattainment areas were defined, each state was then obligated to submit a plan demonstrating how it will attain the air quality standard in each nonattainment area. In the case of general, broad-based plans, the task of assessing the various control options, selecting those control measures which will result in emissions reductions, and preparing the plan must, according to the Act, be assigned by the state to a group consisting of elected officials from the affected localities and representatives of state transportation and air quality planning agencies. However, the final decision as to the contents of the plan and submission of the plan to EPA is the state's responsibility.

A. Northern Virginia Area

For the metropolitan Washington area, classified as a serious nonattainment area, the plan is to be developed and submitted to EPA in three annual phases, starting in the fall of 1992. The first phase of the plan requires that certain specific control measures and other requirements be adopted and submitted to EPA by November 15, 1992; these control measures have been adopted for the Northern Virginia Nonattainment Area. The second phase of a plan requires a strategy to reduce VOCs from the 1990 base year level by 15% by the end of 1996 in order to make progress toward the attainment of the ozone air quality standard. This strategy was due to EPA by November 15, 1993 and has been developed for the Northern Virginia Nonattainment area. The third phase of the plan requires two elements: (i) a strategy to reduce VOCs or NOX from the 1990 base year level by 3.0% per year from 1996 to 1999 and (ii) a demonstration by photochemical modeling to determine the additional amount and appropriate mix of VOCs and NOX emission reductions that are necessary to meet the ozone air quality standard by the attainment date. These elements are due to EPA by November 15, 1994, and any emissions reductions constitute an addition to the 15% emission reduction strategy due in 1993.

B. Richmond Area

For the metropolitan Richmond area, classified as a moderate nonattainment area, the plan is the same as that

described above for the Northern Virginia area except that the strategy to reduce VOCs or NOX from the 1990 base year level by 3.0% per year from 1996 to 1999 is not required. Most of the special control measures for phase one of the plan have been completed for this area.

C. Hampton Roads Area

For the Hampton Roads area, classified as a marginal nonattainment area, the only requirement mandated by the Act is that specific regulatory deficiencies be corrected. The regulatory measures to correct these deficiencies were adopted and submitted to EPA prior to November 15, 1992. No new control measures will be required for this area unless EPA changes the area's nonattainment status from marginal to moderate. Should this occur, any or all of the control measures required for moderate be mandated for affected sources in the Hampton Roads area.

Statutory Authority: § 10.1-1308 of the Code of Virginia.

Written comments may be submitted until 4:30 p.m. on July 1, 1994, to the Manager, Air Programs Section, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240.

Contact: Dr. Kathleen Sands, Policy Analyst, Air Programs Section, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 762-4413.

V.A.R. Doc. No. R94-984; Filed May 11, 1994, 11:39 a.m.

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Air Pollution Control Board intends to consider amending regulations entitled: **VR 120-01. Regulations for the Control and Abatement of Air Pollution: Emission Standards for Sources of Volatile Organic Compounds (Rev. RR)**. The purpose of the proposed action is to develop regulations which will allow the state to reduce volatile organic compounds (VOC) emissions. Under the federal Clean Air Act (Act), Virginia must reduce these emissions by 15% from the 1990 base year level emissions. This must be done by the end of 1996.

Public Meeting: A public meeting will be held by the department in the Board Room, Department of Environmental Quality Office Building, 4900 Cox Road, Innsbrook Corporate Center, Glen Allen, Virginia, at 5 p.m. on June 30, 1994, to discuss the intended action. Unlike a public hearing, which is intended only to receive testimony, this meeting is being held to discuss and exchange ideas and information relative to regulation development.

Accessibility to Persons with Disabilities: The meeting is being held at a public facility believed to be accessible to persons with disabilities. Any person with questions on the

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accessibility of the facility should contact Ms. Doneva Dalton at the Office of Regulatory Services, Department of Environmental Quality, P.O. Box 10009, Richmond, Virginia 23240, or by telephone at (804) 762-4379 or TDD (804) 762-4021. Persons needing interpreter services for the deaf must notify Ms. Dalton no later than June 23, 1994.

Ad Hoc Advisory Group: The department will form an ad hoc advisory group to assist in the development of the regulation. If you want to be on the group, notify the agency contact in writing by 4:30 p.m. on June 23, 1994, and provide your name, address, phone number and the organization you represent (if any). Notification of the composition of the ad hoc advisory group will be sent to all applicants. If you wish to be on the group, you are encouraged to attend the public meeting mentioned above.

Public Hearing Plans: After publication in The Virginia Register of Regulations, the department will hold at least one public hearing to provide opportunity for public comment on any regulation amendments drafted pursuant to this notice.

Need: One of the primary goals of the federal Clean Air Act (Act) is the attainment and maintenance of the National Ambient Air Quality Standards (NAAQS). These standards, designed to protect public health and welfare, apply to six pollutants, of which ozone is the primary focus of this proposed action. Ozone is formed when volatile organic compounds (VOCs) and nitrogen oxides (NOX) in the air react together in the presence of sunlight. VOCs are chemicals contained in gasoline, polishes, paints, varnishes, cleaning fluids, inks, and other household and industrial products. NOX emissions are a byproduct from the combustion of fuels and industrial processes.

The National Ambient Air Quality Standard for ozone is 0.12 parts per million (ppm) and was established by the U.S. Environmental Protection Agency (EPA) to protect the health of the general public with an adequate margin of safety. When concentrations of ozone in the ambient air exceed the federal standard the area is considered to be out of compliance and is classified as "nonattainment." Numerous counties and cities within the Northern Virginia, Richmond, and Hampton Roads areas have been identified as ozone nonattainment areas according to new provisions of the Act.

Virginia is required by the Act to develop plans to ensure that areas will come into compliance with the federal ozone ambient air quality standard. Failure to develop adequate programs to meet the ozone air quality standard (i) will result in continued violations of the standard; (ii) may result in assumption of the program by EPA, at which time the Commonwealth would lose authority over matters affecting its citizens; and (iii) may result in the implementation of sanctions by EPA, such as more restrictive requirements on new major industrial facilities and loss of federal funds for highway construction. Furthermore, if a particular area fails to attain the federal

standard by the legislatively mandated attainment date, EPA is required to reassign it to the next higher classification level (denoting a worse air quality problem), thus subjecting the area to more stringent air pollution control requirements.

The Act requires that regional transportation plans and individual highway projects conform with Virginia's air quality plan. Conformity of transportation plans means that emissions from mobile sources must remain within the emissions budget established in the plan. Conformity determinations must be made when Virginia applies for federal highway funds. In order to make conformity determinations, EPA requires Virginia to submit a plan with an emissions budget and enforceable control measures for implementation of the plan. Once EPA has determined that the plan is complete, aside from the enforceable control measures, Virginia can continue to make conformity determinations provided the enforceable control measures (regulations) are submitted to EPA within one year of the EPA's completeness determination.

A. Northern Virginia Area

The metropolitan Washington area has been designated as a serious nonattainment area under the Act. Consequently, its attainment date is November 15, 1999.

The Act specifies that a plan be developed to ensure that VOC emissions in the area are reduced by 15% by the end of 1996. About half of the VOCs in the area are emitted from cars, trucks, and buses; the other half are emitted from small sources like printing shops, service stations, auto body shops, and people using gasoline-powered equipment, paints, solvents, etc. (Large industrial facilities like power plants and factories emit only about 4.0% of the VOCs in this area.)

The task of assessing the various control options, selecting those control measures which will result in the 15% VOC reductions, and preparing the plan has been assigned by the three states comprising the Metropolitan Washington Area to the Metropolitan Washington Air Quality Committee (MWAQC). MWAQC consists of elected officials from the affected localities and representatives of state transportation and air quality planning agencies from Virginia, Maryland, and the District of Columbia. However, the final decision on the 15% emissions reduction plan and submission to EPA rests with each state.

MWAQC has recommended that Maryland, Virginia, and the District of Columbia submit to EPA a plan that includes a number of control measures to provide emission reduction credits required to achieve the 15% VOC emission reduction target. These control measures will require each jurisdiction to amend emissions standards for certain categories of currently regulated VOC sources and create new standards for other uncontrolled sources. These new and revised emissions standards will result in the reduction of VOC emissions as identified in the MWAQC's 15% emissions reduction plan.

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Currently unregulated sources emitting between 25 and 100 tons per year of VOC emissions, surface cleaning/degreasing operations, graphic arts printing operations, lithographic printing operations, auto body refinishing operations, and sanitary landfill operations are among the many source types from which VOC emissions reductions have been identified in MWAQC's 15% emissions reduction plan. The total reduction target for the metropolitan Washington area is 133 tons per day of VOC emissions, of which 60 tons must come from the Northern Virginia Nonattainment Area. The individual contribution to the overall target for each of the affected source categories is shown in the table below.

Source Category	Reduction Target (TPD)
small sources (25-100 tpy)	0.6
cleaning/degreasing operations	1.5
graphic arts printing operations (including lithographic printing)	1.4
auto body refinishing operations	2.1
sanitary landfill operations	0.4

The control of the emissions from the sources listed above, along with other control measures recommended in the MWAQC plan, will provide the 15% reduction in VOC emissions required by the plan.

In addition, the MWAQC plan also establishes the initial emissions budget for point (large stationary), area (small stationary) and mobile sources. This is done by projecting the 1996 emissions as a 15% reduction from the 1990 baseline emissions. In order to make an acceptable conformity determination, Virginia transportation planning organizations must demonstrate that the mobile source emissions will remain within the mobile source portion of the 1996 emissions budget.

On November 15, 1993, Virginia submitted the draft MWAQC plan for EPA review. On January 20, 1994, EPA determined that the plan was complete except for the enforceable control measures which must be submitted as regulations within one year of EPA's completeness determination. In order for Virginia to continue making conformity determinations for highway projects, regulations covering the sources listed above must be submitted to EPA by January 20, 1995.

B. Richmond Area

The Richmond area has been designated as a moderate nonattainment area under the Act. As such, the Act specifies that the area must reduce its emissions of VOCs by 15% by November 15, 1996. The Act requires that Virginia adopt regulations for sources for which EPA has issued a control technology guideline (CTG) between the time of enactment of the 1990 Amendments to the Act and

the attainment date for the nonattainment area. This requirement pertains to moderate or worse nonattainment areas. A CTG defines what is considered to be reasonably available control technology (RACT) for a specific source category. RACT is the lowest emission limit that a particular source is capable of meeting by the application of control technology that is reasonably available considering technological and economic feasibility. Since the time of enactment, EPA has published CTGs for several categories of sources. A review of existing sources in the Richmond Nonattainment Area identified several sources in the CTG source categories of industrial wastewater operations and synthetic chemical and polymer manufacturing equipment prone to VOC leaks. Consequently, Virginia must develop regulations for these two source types by November 15, 1994.

The Act also provides a process for a state to petition EPA to officially redesignate a nonattainment area to attainment. The Act stipulates that for an area to be redesignated, EPA must fully approve a maintenance plan. A state may submit both the redesignation request and the maintenance plan at the same time, and the EPA review and approval process for both may proceed on a parallel track. The lack of ozone standard violations in the most recent three-year period prior to the redesignation request being approved by EPA, is another condition that must be met before the area can be redesignated. An area is determined to be in violation of the ozone air quality standard if the three-year average of exceedances at any of the area's monitors is greater than one.

A redesignation request for the Richmond Nonattainment Area was submitted to EPA on November 12, 1992. The Commonwealth was able to meet all of the criteria necessary for requesting redesignation, including the lack of ozone violations during the three-year period between 1990 and 1992. In addition, Virginia submitted a maintenance plan demonstrating that, because of permanent and enforceable measures, emissions over the ten years following redesignation would remain within the standards while allowing for growth in population and vehicle miles traveled.

On August 17, 1993, EPA proposed approval of the request and maintenance plan in the Federal Register. Subsequently, EPA withdrew its original proposed approval and on May 3, 1994, issued a final notice of disapproval. This was because of a number of exceedances of the ozone standard recorded at Richmond area ozone monitors during the summer of 1993, which caused the three-year average of exceedances at one of the Richmond area monitors during 1991, 1992 and 1993 to exceed one. In other words, the air quality in the Richmond area had violated (was not attaining) the ozone standard.

Virginia is now obligated to develop a plan to institute control measures to reduce emissions of VOCs in the area by 15% by the end of 1996. The plan is currently being developed and may call for new regulatory requirements on any of the source types listed in this notice. If this is

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the case, pertinent regulations will be promulgated to amend existing emissions standards and create emission standards for sources currently unregulated so that the necessary 15% reduction of VOC emissions will be achieved.

C. Hampton Roads Area

The Hampton Roads area has been designated as a marginal nonattainment area under the Act, and its attainment date was November 15, 1993. As such, the Act specifies that certain deficiencies in the regulatory program in place at the time of the Act's reauthorization in 1990 be corrected to bring it in line with EPA policy.

The Act provides a process whereby EPA must determine whether or not a nonattainment area achieves the air quality standard by the attainment date. Within six months after the attainment date for each nonattainment area, EPA must determine whether the area has attained the ozone standard. This is accomplished by reviewing the state's quality-assured air quality data from the previous three-year period. An area is determined to be in violation of the ozone air quality standard if the three-year average of exceedences at any monitor is greater than one. The Hampton Roads area would achieve attainment status as long as the ozone standard of 0.12 ppm was not exceeded on more than three days at any one ozone monitor in the Hampton Roads area during 1991, 1992, and 1993.

Recent air quality data shows, however, that the Hampton Roads area may not have achieved the standard by the required attainment date. If EPA determines that an ozone air quality standard violation has occurred, it must change the area's nonattainment status from marginal to moderate. If the area's status is changed, it is not clear, at this time, which of the control strategies required in moderate nonattainment areas will be mandated for affected sources in the Hampton Roads area. It is possible that Virginia may be obligated to develop a plan to institute control measures to reduce emissions of VOCs in the area, as was required for the Northern Virginia and Richmond areas. Once completed, the plan may call for new regulatory requirements applying to any of the source types listed in this notice. Consequently, pertinent regulations will be promulgated to amend existing emissions standards and create emission standards for sources currently unregulated in order to achieve the necessary reduction of VOC emissions.

Alternatives:

1. Draft regulations which will provide for implementation of the plans to reduce VOC emissions from the 1990 base year level by 15% by the end of 1996 in order to make progress toward the attainment of the ozone air quality standard in the nonattainment areas and which meet the provisions of the federal Clean Air Act and associated EPA regulations and policies.

2. Make alternative regulatory changes to those required by the 15% emissions reduction plans, thus jeopardizing Virginia's achievement of its required total reduction target. The sanctions for such a failure are the same as those listed below in Alternative 3.

3. Take no action to amend the regulations and assume the associated risks. If Virginia fails to submit the regulations by January 20, 1995, for achieving the reductions required by the 15% plan, Virginia will no longer be able to make conformity determinations and will not be able to apply for federal highway funds. Another consequence of failure to implement the 15% emissions reduction plan would be the imposition of sanctions by EPA. These may include withholding federal highway funds or air quality planning grants, requiring new industries to offset emissions to such a degree that economic growth may be hindered, or imposing a federal plan on the state. Furthermore, if a nonattainment area fails to attain the federal standard for ozone by its attainment date, EPA must reassign it to the next higher classification level (denoting a worse air quality problem), thus subjecting the area to more stringent control requirements.

Costs and Benefits: The department is soliciting comments on the costs and benefits of the alternatives stated above or other alternatives.

Applicable Federal Requirements: The 1990 Amendments to the Clean Air Act (new Act) represent the most comprehensive piece of clean air legislation ever enacted to address air quality planning requirements for areas that had not attained the federal air quality standard for ozone (that is, nonattainment areas). The new Act established a process for evaluating the air quality in each region and identifying and classifying each nonattainment area according to the severity of its air pollution problem. Nonattainment areas are classified as marginal, moderate, serious, severe and extreme. Marginal areas are subject to the least stringent requirements and each subsequent classification (or class) is subject to successively more stringent control measures. Areas in a higher classification of nonattainment must meet the mandates of the lower classifications plus the more stringent requirements of its own class. Virginia's ozone nonattainment areas are classified as marginal for the Hampton Roads Nonattainment Area, moderate for the Richmond Nonattainment Area, and serious for the Northern Virginia Nonattainment Area.

Once the nonattainment areas were defined, each state was then obligated to submit a plan demonstrating how it will attain the air quality standard in each nonattainment area. In the case of general, broad-based plans, the task of assessing the various control options, selecting those control measures which will result in emissions reductions, and preparing the plan must, according to the Act, be assigned by the state to a group consisting of elected officials from the affected localities and representatives of state transportation and air quality planning agencies.

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However, the final decision as to the contents of the plan and submission of the plan to EPA is the state's responsibility.

A. Northern Virginia Area

For the metropolitan Washington area, classified as a serious nonattainment area, the plan is to be developed and submitted to EPA in three annual phases, starting in the fall of 1992. The first phase of the plan requires that certain specific control measures and other requirements be adopted and submitted to EPA by November 15, 1992; these control measures have been adopted for the Northern Virginia Nonattainment Area. The second phase of a plan requires a strategy to reduce VOCs from the 1990 base year level by 15% by the end of 1996 in order to make progress toward the attainment of the ozone air quality standard. This strategy was due to EPA by November 15, 1993, and has been developed for the Northern Virginia Nonattainment area. The third phase of the plan requires two elements: (i) a strategy to reduce VOCs or NOX from the 1990 base year level by 3.0% per year from 1996 to 1999 and (ii) a demonstration by photochemical modeling to determine the additional amount and appropriate mix of VOCs and NOX emission reductions that are necessary to meet the ozone air quality standard by the attainment date. These elements are due to EPA by November 15, 1994, and any emissions reductions constitute an addition to the 15% emission reduction strategy due in 1993.

B. Richmond Area

For the metropolitan Richmond area, classified as a moderate nonattainment area, the plan is the same as that described above for the Northern Virginia area except that the strategy to reduce VOCs or NOX from the 1990 base year level by 3.0% per year from 1996 to 1999 is not required. Most of the special control measures for phase one of the plan have been completed for this area.

C. Hampton Roads Area

For the Hampton Roads area, classified as a marginal nonattainment area, the only requirement mandated by the Act is that specific regulatory deficiencies be corrected. The regulatory measures to correct these deficiencies were adopted and submitted to EPA prior to November 15, 1992. No new control measures will be required for this area unless EPA changes the area's nonattainment status from marginal to moderate. Should this occur, any or all of the control measures required for moderate nonattainment areas may be mandated for affected sources in the Hampton Roads area.

Statutory Authority: § 10.1-1308 of the Code of Virginia.

Written comments may be submitted until 4:30 p.m. on July 1, 1994, to the Manager, Air Programs Section, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240.

Contact: Ellen Snyder, Policy Analyst, Air Programs Section, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 762-4422.

V.A.R. Doc. No. R94-985; Filed May 11, 1994, 11:39 a.m.

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Air Pollution Control Board intends to consider promulgating regulations entitled: **VR 120-50-02. Regulation for Transportation Conformity.** The purpose of the proposed action is to develop a regulation which will establish criteria and procedures for the transportation planning organization to determine whether federally-funded transportation plans, programs, and projects are in conformance with state plans for attaining and maintaining national ambient air quality standards in the Northern Virginia, Richmond, and Hampton Roads nonattainment areas.

Public Meeting: A public meeting will be held by the department in the Board Room, Department of Environmental Quality Office Building, 4900 Cox Road, Innsbrook Corporate Center, Glen Allen, Virginia, at 5 p.m. on June 29, 1994, to discuss the intended action. Unlike a public hearing, which is intended only to receive testimony, this meeting is being held to discuss and exchange ideas and information relative to regulation development.

Accessibility to Persons with Disabilities: The meeting is being held at a public facility believed to be accessible to persons with disabilities. Any person with questions on the accessibility of the facility should contact Ms. Doneva Dalton at the Office of Regulatory Services, Department of Environmental Quality, P.O. Box 10009, Richmond, Virginia 23240, or by telephone at (804) 762-4379 or TDD (804) 762-4021. Persons needing interpreter services for the deaf must notify Ms. Dalton no later than June 22, 1994.

Ad Hoc Advisory Group: The department is soliciting comments on the advisability of forming an ad hoc advisory group, utilizing a standing advisory committee, or consulting with groups or individuals registering interest in working with the department to assist in the drafting and formation of any proposal. Any comments relative to this issue must be submitted in accordance with the procedures described under the "Request for Comments" section above.

Public Hearing Plans: After publication in The Virginia Register of Regulations, the department will hold at least one public hearing to provide opportunity for public comment on any regulation amendments drafted pursuant to this notice.

Need: One of the primary goals of the federal Clean Air Act (Act) is the attainment and maintenance of the National Ambient Air Quality Standards (NAAQS). These standards, designed to protect public health and welfare,

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apply to six pollutants, including ozone. Ozone is formed when volatile organic compounds and nitrogen oxides in the air react together in the presence of sunlight. The National Ambient Air Quality Standard for ozone was established by the U.S. Environmental Protection Agency (EPA) to protect the health of the general public with an adequate margin of safety. When concentrations of ozone in the ambient air exceed the federal standard, the area is considered to be out of compliance and is classified as "nonattainment." Numerous counties and cities within the Northern Virginia, Richmond, and Hampton Roads areas have been identified as ozone nonattainment areas.

Virginia is required by the Act to develop a State Implementation Plan (SIP) to ensure that nonattainment areas will come into compliance with the federal ozone standard. Failure to develop adequate programs to meet the ozone standard (i) will result in continued violations of the standard; (ii) may result in assumption of the program by EPA, at which time the Commonwealth would lose authority over matters affecting its citizens; and (iii) may result in the imposition of sanctions by EPA, such as more restrictive requirements on new major industrial facilities and loss of federal funds for highway construction. Furthermore, if a particular area fails to attain the federal standard by the legislatively mandated attainment date, EPA is required to reassign it to the next higher classification level (denoting a worse air quality problem), thus subjecting the area to more stringent air pollution control requirements.

Section 176(c) of the Act states, "No department, agency, or instrumentality of the Federal Government shall engage in, support in any way or provide financial assistance for, license or permit, or approve, any activity which does not conform to a [State Implementation Plan]." This requires metropolitan planning organizations (MPOs) and the United States Department of Transportation (DOT) to make determinations that federally-funded transportation plans, programs, and projects conform with Virginia's SIP. "Conformity" means that the activity conforms to the SIP's purpose of eliminating or reducing the severity and number of violations of the NAAQS and achieving expeditious attainment of such standards, and will not (i) cause or contribute to any new violation of any standard in any area, (ii) increase the frequency or severity of any existing violation of any standard in any area, or (iii) delay timely attainment of any standard or any required interim emission reductions or other milestones in any area.

The Act ties conformity to attainment and maintenance of the NAAQS. Thus, a transportation activity must not adversely affect implementation of the SIP or the timely attainment and maintenance of the NAAQS. The Act emphasizes reconciling the emissions from transportation activities with the SIP rather than simply providing for the implementation of SIP measures. This integration of transportation activities and air quality planning is intended to protect the integrity of the SIP by helping to ensure that SIP emissions growth projections are not

exceeded, emissions reduction targets are met, and maintenance efforts are not undermined.

EPA promulgated a rule (58 FR 62188, November 24, 1993) which establishes the criteria and procedures governing the determination of conformity for all federally-funded transportation plans, programs, and projects in nonattainment areas. This rule requires Virginia to submit to EPA, by November 24, 1994, a revision to the SIP that establishes conformity criteria and procedures consistent with the transportation conformity rule promulgated by EPA. The transportation conformity rule requires MPOs and DOT to make conformity determinations on metropolitan transportation plans and transportation improvement programs (TIPs) before they are adopted, approved, or accepted. In addition, highway or transit projects which are funded or approved by the Federal Highway Administration (FHWA) or the Federal Transit Administration (FTA) must be found to conform before they are approved or funded by DOT or an MPO.

Alternatives:

1. Draft a regulation which will provide processes for determining if transportation plans, programs, and projects will conform to the SIP in order to meet the provisions of the Clean Air Act and associated EPA regulations.

2. Take no action to amend the regulations. However, if Virginia fails to submit the regulation, MPOs and DOT will not be able to make the conformity determinations required of them prior to commencing any applicable project. Another consequence of failure to amend the regulations be the imposition of sanctions by EPA. These may include withholding federal highway funds or air quality planning grants, requiring new industries to offset emissions to such a degree that economic growth may be hindered, or imposing a federal plan on the state.

Costs and Benefits: The department is soliciting comments on the costs and benefits of the alternatives stated above or other alternatives.

Statutory Authority: § 10.1-1308 of the Code of Virginia.

Written comments may be submitted until 4:30 p.m. on June 30, 1994, to the Manager, Air Programs Section, Department of Environmental Quality, P. O. Box 10009, Richmond, VA 23240.

Contact: Mary E. Major, Policy Analyst Senior, Air Programs Section, Department of Environmental Quality, P. O. Box 10009, Richmond, VA 23240, telephone (804) 762-4423.

VA.R. Doc. No. R94-986; Filed May 11, 1994, 11:40 a.m.

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† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Air Pollution Control Board intends to consider promulgating regulations entitled: **VR 120-50-03. Regulation for General Conformity.** The purpose of the proposed action is to develop a regulation which will establish criteria and procedures for federal agencies to determine that federal nontransportation related actions are in conformance with state plans for attaining and maintaining national ambient air quality standards in the Northern Virginia, Richmond, and Hampton Roads nonattainment areas.

Public Meeting: A public meeting will be held by the department in the Board Room, Department of Environmental Quality Office Building, 4900 Cox Road, Innsbrook Corporate Center, Glen Allen, Virginia, at 5 p.m. on June 29, 1994, to discuss the intended action. Unlike a public hearing, which is intended only to receive testimony, this meeting is being held to discuss and exchange ideas and information relative to regulation development.

Accessibility to Persons with Disabilities: The meeting is being held at a public facility believed to be accessible to persons with disabilities. Any person with questions on the accessibility of the facility should contact Ms. Doneva Dalton at the Office of Regulatory Services, Department of Environmental Quality, P.O. Box 10009, Richmond, Virginia 23240, or by telephone at (804) 762-4379 or TDD (804) 762-4021. Persons needing interpreter services for the deaf must notify Ms. Dalton no later than June 22, 1994.

Ad Hoc Advisory Group: The department is soliciting comments on the advisability of forming an ad hoc advisory group, utilizing a standing advisory committee, or consulting with groups or individuals registering interest in working with the department to assist in the drafting and formation of any proposal. Any comments relative to this issue must be submitted in accordance with the procedures described under the "Request for Comments" section above.

Public Hearing Plans: After publication in The Virginia Register of Regulations, the department will hold at least one public hearing to provide opportunity for public comment on any regulation amendments drafted pursuant to this notice.

Need: One of the primary goals of the federal Clean Air Act (Act) is the attainment and maintenance of the National Ambient Air Quality Standards (NAAQS). These standards, designed to protect public health and welfare, apply to six pollutants, including ozone. Ozone is formed when volatile organic compounds and nitrogen oxides in the air react together in the presence of sunlight. The National Ambient Air Quality Standard for ozone was established by the U.S. Environmental Protection Agency (EPA) to protect the health of the general public with an adequate margin of safety. When concentrations of ozone

in the ambient air exceed the federal standard, the area is considered to be out of compliance and is classified as "nonattainment." Numerous counties and cities within the Northern Virginia, Richmond, and Hampton Roads areas have been identified as ozone nonattainment areas.

Virginia is required by the Act to develop a State Implementation Plan (SIP) to ensure that nonattainment areas will come into compliance with the federal ozone standard. Failure to develop adequate programs to meet the ozone standard (i) will result in continued violations of the standard; (ii) may result in assumption of the program by EPA, at which time the Commonwealth would lose authority over matters affecting its citizens; and (iii) may result in the imposition of sanctions by EPA, such as more restrictive requirements on new major industrial facilities and loss of federal funds for highway construction. Furthermore, if a particular area fails to attain the federal standard by the legislatively mandated attainment date, EPA is required to reassign it to the next higher classification level (denoting a worse air quality problem), thus subjecting the area to more stringent air pollution control requirements.

Section 176(c) of the Act states, "No department, agency, or instrumentality of the federal government shall engage in, support in any way or provide financial assistance for, license or permit, or approve, any activity which does not conform to a [State Implementation Plan]." This requires federal agencies to make determinations that general federal actions, such as prescribed burning, military base closings, and real estate developments, conform with Virginia's SIP. (Conformity of transportation plans is covered in a separate rule.) "Conformity" means that a project conforms to the SIP's purpose of eliminating or reducing the severity and number of violations of the NAAQS and achieving expeditious attainment of such standards, and will not (i) cause or contribute to any new violation of any standard in any area, (ii) increase the frequency or severity of any existing violation of any standard in any area, or (iii) delay timely attainment of any standard or any required interim emission reductions or other milestones in any area.

The Act ties conformity to attainment and maintenance of the NAAQS. Thus, a federal action must not adversely affect implementation of the SIP or the timely attainment and maintenance of the NAAQS. The Act emphasizes reconciling the emissions from federal actions with the SIP rather than simply providing for the implementation of SIP measures. This integration of federal actions and air quality planning is intended to protect the integrity of the SIP by helping to ensure that SIP emission growth projections are not exceeded, emissions reduction targets are met, and maintenance efforts are not undermined.

EPA promulgated a rule (58 FR 63214, November 30, 1993) which establishes the criteria and procedures governing the determination of conformity for all federal actions in nonattainment areas. This rule requires Virginia to submit to EPA, by November 30, 1994, a revision to the

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SIP that establishes conformity criteria and procedures consistent with the general conformity rule promulgated by EPA. The general conformity rule (i) covers direct and indirect emissions of ozone and its precursors that are caused by a federal action, are reasonably foreseeable, and can be practicably controlled by a federal agency through its continuing program responsibility; (ii) establishes procedural requirements, including requiring federal agencies to make their conformity determinations available to the public and to air quality regulatory agencies; and (iii) provides options to satisfy air quality criteria, and requires the federal action to also meet any applicable SIP requirements and emission milestones. Each federal agency must determine that any actions covered by the rule conform to the SIP before the action is taken.

Alternatives:

1. Draft a regulation which will provide processes for determining if federal projects will conform to the SIP in order to meet the provisions of the Clean Air Act and associated EPA regulations.
2. Take no action to amend the regulations. However, if Virginia fails to submit the regulation, federal agencies will not be able to make the conformity determinations required of them prior to commencing any applicable project. Another consequence of failure to amend the regulations be the imposition of sanctions by EPA. These may include withholding federal highway funds or air quality planning grants, requiring new industries to offset emissions to such a degree that economic growth may be hindered, or imposing a federal plan on the state.

Costs and Benefits: The department is soliciting comments on the costs and benefits of the alternatives stated above or other alternatives.

Statutory Authority: § 10.1-1308 of the Code of Virginia.

Written comments may be submitted until 4:30 p.m. on June 30, 1994, to the Manager, Air Programs Section, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240.

Contact: Karen Sabasteanski, Policy Analyst, Air Programs Section, Department of Environmental Quality, P. O. Box 10009, Richmond, VA 23240, telephone (804) 762-4426.

V.A.R. Doc. No. R94-987; Filed May 11, 1994, 11:40 a.m.

DEPARTMENT OF EDUCATION (STATE BOARD OF)

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Board of Education intends to consider amending regulations entitled: **VR 270-01-0009. Regulations Governing Literary**

Loan Applications in Virginia. The purpose of the proposed action is to amend existing regulations to conform to statutes amended by the 1989, 1990, 1991, 1994 sessions of the General Assembly and to increase the maximum loan amount for constructing a new school from \$2.5 million to \$5 million. The agency intends to hold a public hearing on the proposed regulation after publication.

Statutory Authority: §§ 22.1-140 and 22.1-142 of Title 22.1 of the Code of Virginia and Article VIII of the Constitution of Virginia.

Written comments may be submitted until June 29, 1994.

Contact: Kathryn S. Kitchen, Division Chief, Finance, Department of Education, P. O. Box 2120, Richmond, VA 23216-2120.

V.A.R. Doc. No. R94-966; Filed May 9, 1994, 2:51 p.m.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Board of Education intends to consider amending regulations entitled: **VR 270-01-0014. Regulations Governing the Management of the Student's Scholastic Record.** The purpose of the proposed action is to revise the regulations to comport with changes in the Virginia Code and to reflect changes in policies and procedures governing the management of student records. The agency intends to hold a public hearing on the proposed amendments after publication.

Statutory Authority: §§ 4 and 5(e) of Article VIII of the Constitution of Virginia and §§ 22.1-16 and 22.1-20 of the Code of Virginia.

Written comments may be submitted until June 16, 1994.

Contact: Michelle Hathcock, Associate Specialist, Department of Education, P. O. Box 2120, Richmond, VA 23216-2120, telephone (804) 225-2339.

V.A.R. Doc. No. R94-897; Filed April 18, 1994, 3:40 p.m.



DEPARTMENT OF HEALTH (STATE BOARD OF)

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Board of Health intends to consider promulgating regulations entitled: **VR 355-17-300. Fees for Permits Involving Land Application or Marketing or Distribution of Biosolids.** The purpose of the proposed action is to develop a

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regulation setting forth a fee assessment and collection system for permits issued for land application or marketing or distribution of biosolids. This permit fee system will replace the Virginia Pollution Abatement (VPA) fees for Land Application of Municipal Sludge (VR 680-01-01). A public hearing will be held in July or August 1994.

Statutory Authority: § 32.1-164.5 of the Code of Virginia (Chapter 288, 1994 Acts of Assembly).

Written comments may be submitted until June 17, 1994.

Contact: C.M. Sawyer, P.E., Division Director, Department of Health, Division of Wastewater Engineering, P. O. Box 2448, Richmond, VA 23218, telephone (804) 786-1755 or FAX (804) 786-5567.

V.A.R. Doc. No. R94-899; Filed April 20, 1994, 12:30 p.m.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Board of Health intends to consider amending regulations entitled: **VR 355-20-100 (formerly VR 355-20-01). Virginia Radiation Protection Regulations.** The proposed action is to adopt the 1991 version of the "Suggested State Regulations for Control of Radiation" published by the Conference of Radiation Control Program Directors, Inc.; revise the protection standards resulting from changes to 10 CFR 20; and consider adoption of comments solicited from the public. The agency intends to hold a public hearing on the proposed regulation after publication.

Purpose: The purpose of this Notice of Intended Regulatory Action is to solicit public comments regarding revisions to the Virginia Radiation Protection Regulations. The agency intends to adopt the model regulations contained in the document, "Suggested State Regulations for Control of Radiation," published by the Conference of Radiation Control Program Director, Inc. (CRCPD) and available from CRCPD, 205 Capital Avenue, Frankfort, Kentucky 40601, telephone (502) 227-4543. The revisions also include replacing Part V, radiation protection standards, with the new federal Part 10 CFR 20 standards.

A summary of changes proposed by the agency's staff follows:

1. Update regulations from the latest version of the "Suggested State Regulations for Control of Radiation."
2. Implement Code of Virginia provisions for bonding of radioactive material licensees.
3. Remove all references to radioactive materials regulated by NRC and NRC Agreement states in Part IV.
4. Adopt the new federal 10 CFR 20 in Part V,

radiation protection standards.

5. Adopt provisions of the Mammography Quality Standards Act.

The agency requests public comment for the following issues:

1. What qualifications should private inspectors have? Should individuals be allowed to work as interns and the supervisor not be on site for all of the surveys performed by the intern?
2. Should there be other categories of private inspectors besides diagnostic x-ray and radiation therapy machines, such as mammography, dental, CT, or others? What qualifications should they have?
3. Should the agency specify equipment used by private inspectors and require proof of equipment calibrations?
4. What data should private inspectors report to the agency for it to certify x-ray machines?
5. Should there be any difference in what data the private inspector provides the agency for compliant machines versus noncompliant machines?
6. Should the inspection procedures be prescriptive, or should the agency provide guidance for the conduct of the inspection, or should the inspection procedure be left to the private inspector's judgment?
7. Should x-ray equipment manufactured prior to September 1974 (the date that the U.S. FDA began certification of x-ray machines manufactured for use in the healing arts) be certified for use in the healing arts after the year 2000?
8. Should portable x-ray machines be used as fixed machines in dental and medical facilities?
9. Should stretch cords be allowed for dental intraoral and panoramic machines?
10. Should dosimetry be eliminated for dental facilities that use machines with stretch cords or have open bay operatories?
11. How should the agency address the issue of exposure versus dose that is reported for occupational workers while performing interventional diagnostic procedures?
12. What limits should be placed on fluoroscopic x-ray machines that have an output rate exceeding 20 R/min?
13. Should nonimage-intensified fluoroscopic machines be certified for use in the healing arts?

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14. What elements should a quality assurance program have at a facility with x-ray equipment used in the healing arts? Examples are processor temperature and time, fog measurements, sensitometric measurements, phantom exposure trends, and phantom image scores.

15. How frequently should analytical x-ray diffraction equipment and industrial x-ray equipment be inspected?

16. Should the shielding design of linear accelerators producing beam energies greater than 18 MeV be required to include calculations of neutron production or should the facility measure the neutron production for evaluating the effectiveness of the shielding design?

Any individual or organization interested in participating in the development of specific rules and regulations should also contact the Bureau of Radiological Health and ask to be placed on the interested parties list.

The Radiation Advisory Board will review all public comments and assist the agency in the review and development of the regulations for the Board of Health.

Statutory Authority: § 32.1-299 of the Code of Virginia.

Written comments may be submitted until June 17, 1994.

Contact: Leslie P. Foldesi, Director, Bureau of Radiological Health, 1500 E. Main St., Room 104A, Richmond, VA 23219, telephone (804) 786-5932, FAX (804) 786-6979 or toll-free 1-800-468-0138.

VA.R. Doc. No. R94-755; Filed March 30, 1994, 10:19 a.m.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Board of Health intends to consider amending regulations entitled: **VR 355-29-100 (Formerly 355-29-01). Regulations Governing Vital Records.** The purpose of the proposed action is to amend fees charged for certification of vital records as authorized by the 1994 General Assembly through passage of SB 402. One public hearing is planned during the public comment period following publication of the proposed revisions.

Statutory Authority: §§ 32.1-273 and 32.1-273.1 (Chapter 373, 1994 Acts of Assembly) of the Code of Virginia.

Written comments may be submitted until June 15, 1994.

Contact: Deborah M. Little, Director, Office of Vital Records and Health Statistics, Department of Health, James Madison Building, Room 305, 109 Governor Street, Richmond, VA 23219, telephone (804) 371-6077.

VA.R. Doc. No. R94-898; Filed April 19, 1994, 11:41 a.m.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Board of Health intends to consider amending regulations entitled: **VR 355-30-102. Virginia State Medical Facilities Plan: Perinatal Services.** The purpose of the proposed action is to amend the criteria and standards for approval of projects for establishment of neonatal special care services. A public hearing is planned during the public comment period to commence with the publication of the regulations.

Statutory Authority: §§ 32.1-12 and 32.1-102.1 et seq. of the Code of Virginia.

Written comments may be submitted until May 30, 1994.

Contact: Paul E. Parker, Director, Office of Resources Development, Department of Health, 1500 E. Main St., Suite 105, Richmond, VA 23219, telephone (804) 786-7463.

VA.R. Doc. No. R94-741; Filed March 25, 1994, 1:15 p.m.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Board of Health intends to consider amending regulations entitled: **VR 355-30-104. Virginia State Medical Facilities Plan: General Surgical Services.** The purpose of the proposed action is to amend the criteria and standards for approval of projects involving surgical services and facilities. A public hearing is planned during the public comment period to commence with the publication of the regulations.

Statutory Authority: §§ 32.1-12 and 32.1-102.1 et seq. of the Code of Virginia.

Written comments may be submitted until May 30, 1994.

Contact: Paul E. Parker, Director, Office of Resources Development, Department of Health, 1500 E. Main St., Suite 105, Richmond, VA 23219, telephone (804) 786-7463.

VA.R. Doc. No. R94-740; Filed March 25, 1994, 1:15 p.m.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Board of Health intends to consider amending regulations entitled: **VR 355-30-107. Virginia State Medical Facilities Plan: Medical Rehabilitation Services.** The purpose of the proposed action is to amend the criteria and standards for approval of projects which involve medical rehabilitation services and facilities. A public hearing is planned during the public comment period to commence with the publication of the regulations.

Statutory Authority: §§ 32.1-12 and 32.1-102.1 et seq. of the

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Code of Virginia.

VA.R. Doc. No. R94-962; Filed May 11, 1994, 10:14 a.m.

Written comments may be submitted until May 30, 1994.

Contact: Paul E. Parker, Director, Office of Resources Development, Department of Health, 1500 E. Main St., Suite 105, Richmond, VA 23219, telephone (804) 786-7463.

VA.R. Doc. No. R94-744; Filed March 28, 1994, 11 a.m.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Board of Health intends to consider amending regulations entitled: **VR 355-30-111. Virginia State Medical Facilities Plan: Radiation Therapy Services.** The purpose of the proposed action is to amend the criteria and standards for approval of projects which involve radiation therapy services. A public hearing is planned during the public comment period to commence with the publication of the regulations.

Statutory Authority: §§ 32.1-12 and 32.1-102.1 et seq. of the Code of Virginia.

Written comments may be submitted until May 30, 1994.

Contact: Paul E. Parker, Director, Office of Resources Development, Department of Health, 1500 E. Main St., Suite 105, Richmond, VA 23219, telephone (804) 786-7463.

VA.R. Doc. No. R94-742; Filed March 28, 1994, 9:05 a.m.

STATE COUNCIL OF HIGHER EDUCATION

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Council of Higher Education intends to consider promulgating regulations entitled: **State Postsecondary Review Program.** The purpose of the proposed action is to implement federally mandated provisions of Title IV, Part H, Subpart I of the Higher Education Act of 1965, as amended; and the related federal regulations promulgated by the U.S. Department of Education as 34 CFR Part 667. The agency intends to hold a public hearing on the proposed regulation after publication.

Statutory Authority: Designation of SCHEV as Virginia's SPRE by Governor Wilder, letter of August 31, 1993; and §§ 23-9.6:1 and 23-261 of the Code of Virginia.

Written comments may be submitted until June 30, 1994.

Contact: John Molnar, Coordinator of Institutional Approval, State Council of Higher Education, 101 N. 14th Street, SCHEV, Richmond, VA 23219, telephone (804) 225-2634.

VIRGINIA MANUFACTURED HOUSING BOARD

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Virginia Manufactured Housing Board intends to consider amending regulations entitled: **VR 449-01-02. Manufactured Housing Licensing and Transaction Recovery Fund Regulations.** The purpose of the proposed action is to amend fee schedules and licensing requirements based on legislative changes made by the 1994 General Assembly. The board will hold a public hearing on proposed amendments to the proposed regulations after publication.

Statutory Authority: § 36-85.18 of the Code of Virginia.

Written comments may be submitted until June 2, 1994.

Contact: Curtis L. McIver, Associate Director, Department of Housing and Community Development, 501 N. 2nd Street, Richmond, VA 23219, telephone (804) 371-7160.

VA.R. Doc. No. R94-817; Filed April 12, 1994, 11:27 a.m.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (BOARD OF)

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Medical Assistance Services intends to consider amending regulations entitled: **VR 460-02-4.1920. Methods and Standards for Establishing Payment Rates – Other Types of Care: State Agency Fee Schedule.** The purpose of the proposed action is to implement a new medical and surgical fee schedule for the agency based on the federal Resource Based Relative Value Scale (RBRVS). The agency does not intend to hold a public hearing on this issue.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Written comments may be submitted until June 29, 1994, to Richard Weinstein, Manager, Division of Cost Settlement and Audit, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-8850.

VA.R. Doc. No. R94-953; Filed May 5, 1994, 11:22 a.m.

Notices of Intended Regulatory Action

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Medical Assistance Services intends to consider amending regulations entitled: **VR 460-02-4.1920. Methods and Standards for Establishing Payment Rates - Other Types of Care: Reimbursement for Organ Transplantation Services.** The purpose of the proposed action is to modify and clarify the reimbursement methodology for organ transplantation services. The agency does not intend to hold public hearings on this issue.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Written comments may be submitted until June 15, 1994, to Betty Cochran, Director, Division of Quality Care Assurance, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-8850.

V.A.R. Doc. No. R94-900; Filed April 25, 1994, 11:19 a.m.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Medical Assistance Services intends to consider amending regulations entitled: **Income Scale for Indigent Children.** The purpose of the proposed action is to properly define in the State Plan the income methodology necessary to determine eligibility for children ages 6 to 19 to meet the requirements of the General Assembly and HCFA. The agency does not intend to conduct public hearings regarding this regulatory change.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Written comments may be submitted until June 1, 1994, to Roberta Jonas, Policy Division, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 E. Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-8850.

V.A.R. Doc. No. R94-795; Filed April 11, 1994, 11:03 a.m.

BOARD OF MEDICINE

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Medicine intends to consider amending regulations entitled: **VR**

465-02-1. Regulations Governing the Practice of Medicine, Osteopathy, Podiatry, Chiropractic, Clinical Psychology and Acupuncture. The purpose of the proposed action is to amend sections pertaining to unprofessional conduct, sections pertaining to examinations for chiropractic licensure, and the section pertaining to physician acupuncturists. There will be no public hearing unless requested. The regulations further specify statutory changes.

Statutory Authority: §§ 54.1-2400, 54.1-2914, and 54.1-2931 of the Code of Virginia.

Written comments may be submitted until June 17, 1994, to Hilary H. Conner, M.D., Board of Medicine, 6606 West Broad Street, Richmond, VA 23230-1717.

Contact: Eugenia Dorson, Deputy Executive Director, Board of Medicine, 6606 West Broad Street, Richmond, VA 23230-1717, telephone (804) 662-9908 or (804) 662-7197/TDD ☎

V.A.R. Doc. No. R94-896; Filed April 22, 1994, 4:06 p.m.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Medicine intends to consider amending regulations entitled: **VR 465-10-01. Certification of Radiological Technology Practitioners.** The purpose of the proposed action is to amend the regulations due to new statutory changes as mandated by the General Assembly. The agency intends to hold a public hearing on the proposed amendments after publication.

Statutory Authority: §§ 54.1-2956.8:1 and 54.1-2956.8:2 (Chapter 803, 1994 Acts of Assembly) and § 54.1-2400 of the Code of Virginia.

Written comments may be submitted until June 16, 1994, to Hilary H. Conner, M.D., Board of Medicine, 6606 West Broad Street, Richmond, VA 23230-1717.

Contact: Eugenia Dorson, Deputy Executive Director, Board of Medicine, 6606 West Broad Street, Richmond, VA 23230-1717, telephone (804) 662-9908 or (804) 662-7197/TDD ☎

BOARD OF PHARMACY

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Pharmacy intends to consider amending regulations entitled: **VR 530-01-1. Regulations of the Board of Pharmacy.** The purpose of the proposed action is to promulgate regulations necessary to implement legislation enacted by the 1994 General Assembly relating to licensure of

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graduates of foreign schools of pharmacy. The agency intends to hold a public hearing on the proposed regulations after publication.

Statutory Authority: §§ 54.1-2400 (6), 54.1-3307, and 54.1-3312 of the Code of Virginia.

Written comments may be submitted until July 1, 1994.

Contact: Scotti W. Milley, Executive Director, Board of Pharmacy, 6606 West Broad Street, 4th Floor, Richmond, VA 23230, telephone (804) 662-9911.

V.A.R. Doc. No. R94-952; Filed May 1, 1994, 8:45 a.m.

BOARD OF PROFESSIONAL COUNSELORS

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Professional Counselors intends to consider amending regulations entitled: **VR 560-01-03. Regulations Governing the Certification of Substance Abuse Counselors.** The proposed regulations establish standards of practice for certified substance abuse counseling including education, supervised experience and examination for certification. The agency intends to hold a public hearing on the proposed amendments after publication.

Statutory Authority: §§ 54.1-2400 and 54.1-3505 of the Code of Virginia.

Written comments may be submitted until June 15, 1994, to Evelyn B. Brown, Department of Health Professions, 6606 West Broad Street, 4th Floor, Richmond, VA 23230-1717.

Contact: Evelyn B. Brown, Executive Director or Bernice Parker, Administrative Assistant, Department of Health Professions, 6606 West Broad Street, Richmond, VA 23230-1717, telephone (804) 662-7328.

V.A.R. Doc. No. R94-901; Filed April 25, 1994, 2:38 p.m.

DEPARTMENT OF SOCIAL SERVICES (STATE BOARD OF)

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Board of Social Services intends to consider amending regulations entitled: **VR 615-01-29. Aid to Families with Dependent Children (AFDC) Program - Disregarded Income and Resources.** The purpose of the proposed regulation is to exempt all bona fide loans from consideration, both as income and as a resource, in evaluating financial eligibility for AFDC. A public hearing is not planned. The State

Board of Social Services will consider public comments on the proposed regulations at its regularly scheduled meeting.

Statutory Authority: § 63.1-25 of the Code of Virginia and 45 CFR 233.20(a)(3)(iv)(B) and (xxi).

Written comments may be submitted until June 2, 1994, to Constance O. Hall, AFDC Program Manager, Division of Benefit Programs, Department of Social Services, 730 E. Broad St., Richmond, VA 23219-1849.

Contact: Peggy Friedenberg, Legislative Analyst, 730 E. Broad Street, Richmond, VA 23219-1849, telephone (804) 692-1820.

V.A.R. Doc. No. R94-816; Filed April 12, 1994, 4:50 p.m.

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Board of Social Services intends to consider repealing regulations entitled: **VR 615-28-01. Minimum Standards for Licensed Independent Foster Homes.** The purpose of the proposed action is to repeal the 1949 Standards for Licensed Independent Foster Homes. Promulgation of new standards for licensed independent foster homes is planned. No public hearings are planned. Comments may be presented to the State Board of Social Services to be considered at its regularly scheduled meeting.

Statutory Authority: § 63.1-202 of the Code of Virginia.

Written comments may be submitted until June 30, 1994, to Doris Jenkins, Division of Licensing Programs, Department of Social Services, 730 E. Broad Street, Richmond, VA 23219.

Contact: Peggy Friedenberg, Policy Analyst, Bureau of Governmental Affairs, Department of Social Services, 730 East Broad Street, Richmond, VA 23219-1849, telephone (804) 692-1820.

V.A.R. Doc. No. R94-964; Filed May 10, 1994, 4:39 p.m.

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Board of Social Services intends to promulgate regulations entitled: **VR 615-28-01:1. Minimum Standards for Licensed Independent Foster Homes.** The purpose of the proposed action is to promulgate new standards for independent foster homes to address the issues that will ensure the safety and well-being of children placed in these homes. No public hearings are planned. Comments may be presented to the State Board of Social Services to be considered at its regularly scheduled meeting.

Statutory Authority: § 63.1-202 of the Code of Virginia.

Notices of Intended Regulatory Action

Written comments may be submitted until June 30, 1994, to Doris Jenkins, Division of Licensing Programs, Department of Social Services, 730 E. Broad St., Richmond, VA 23219.

Contact: Peggy Friedenberg, Policy Analyst, Bureau of Governmental Affairs, Department of Social Services, 730 East Broad Street, Richmond, VA 23219-1849, telephone (804) 692-1820.

V.A.R. Doc. No. R94-965; Filed May 10, 1994, 4:39 p.m.

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Board of Social Services intends to consider promulgating regulations entitled: **VR 615-46-03. Use of the Uniform Assessment Instrument for Assessing Long-Term Care Needs in Local Departments of Social Services.** The purpose of the proposed action is to set forth the Uniform Assessment Instrument for use in determining care needs for customers accessing any publicly funded long-term care service through local departments of social services.

Statutory Authority: HJR 601 (1993).

Written comments may be submitted until July 1, 1994, to Helen Leonard, Adult Services Program Manager, Department of Social Services, 730 East Broad St., Richmond, VA 23219-1849.

Contact: Peggy Friedenberg, Regulatory Coordinator, Bureau of Governmental Affairs, Department of Social Services, 730 E. Broad Street, Richmond, VA 23219-1820, telephone (804) 692-1820.

V.A.R. Doc. No. R94-963; Filed May 10, 1994, 4:39 p.m.

PROPOSED REGULATIONS

For information concerning Proposed Regulations, see information page.

Symbol Key

Roman type indicates existing text of regulations. *Italic type* indicates proposed new text. Language which has been stricken indicates proposed text for deletion.

DEPARTMENT OF EDUCATION (STATE BOARD OF)

Title of Regulation: VR 270-01-0009. Regulations Governing Literary Loan Applications in Virginia.

Statutory Authority: Article VIII, § 8 of the Constitution of Virginia; §§ 22.1-16, 22.1-140 and 22.1-142 of the Code of Virginia.

The Board Education has **WITHDRAWN** the amendments to the proposed regulation entitled, "VR 270-01-0009, Regulations Governing Literary Loan Applications in Virginia," published in 9:17 VA.R. 2704-2707 May 17, 1993. The agency intends to publish new proposed regulations at a later date.

VA.R. Doc. No. R94-959; Filed May 9, 1994, 2:50 p.m.

FINAL REGULATIONS

For information concerning Final Regulations, see information page.

Symbol Key

Roman type indicates existing text of regulations. *Italic type* indicates new text. Language which has been stricken indicates text to be deleted. [Bracketed language] indicates a substantial change from the proposed text of the regulations.

DEPARTMENT OF CONSERVATION AND RECREATION

Title of Regulation: VR 217-00-00. Regulatory Public Participation Procedures.

Statutory Authority: §§ 9-6.14:7.1 and 10.1-104 of the Code of Virginia.

Effective Date: June 29, 1994.

Summary:

This action is necessary to replace existing emergency Regulatory Public Participation Procedures with permanent regulations which will comply with new provisions of the Administrative Process Act (APA) enacted by the 1993 General Assembly. These amendments establish, in regulation, various provisions to ensure that interested persons have the necessary information to comment in a meaningful, timely fashion during all phases of the regulatory process. These amendments are consistent with those of the other agencies within the Natural Resources Secretariat.

The amendments contain a number of new provisions. Specifically, they include a definition for "participatory approach" which means the methods for the use of an ad hoc advisory group or panel, standing advisory committee, consultation with groups or individuals or a combination of methods; require the use of the participatory approach upon the receipt of written requests from five persons during the associated comment period; expand the department's procedures for establishing and maintaining lists of persons expressing an interest in the adoption, amendment or repeal of regulations; expand the information required in the Notice of Intended Regulatory Action to include a description of the subject matter and intent of the planned regulation and to include a statement inviting comment on whether the Director of the Department of Conservation and Recreation should use the participatory approach to assist in regulation development; expand the information required in the Notice of Public Comment to include the identity of localities affected by the proposed regulation and to include a statement on the rationale or justification for the new provisions of the regulation from the standpoint of the public's health, safety or welfare; and require that a draft summary of comments be sent to all public commenters on the proposed regulation at least five days before final adoption of the regulation.

Summary of Public Comment and Agency Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the Office of the Registrar of Regulations.

Agency Contact: Copies of the regulation may be obtained from Leon E. App, Regulatory Coordinator, Department of Conservation and Recreation, 203 Governor Street, Suite 302, Richmond, VA 23219, telephone (804) 786-4570. There may be a charge for copies.

VR 217-00-00. Regulatory Public Participation Procedures.

§ 1. Definitions.

A. The following words and terms, when used in this regulation, shall have the following meaning unless the context clearly indicates otherwise:

"Administrative Process Act" means Chapter 1.1:1 (§ 9-6.14:1 et seq.) of Title 9 of the Code of Virginia.

"Agency" means the Department of Conservation and Recreation, including staff, etc., established pursuant to Virginia law that implements programs and provides administrative support to the approving authority.

"Approving authority" means the Director of the Department of Conservation and Recreation established pursuant to Virginia law as the legal authority to adopt regulations.

"Director" means the Director of the Department of Conservation and Recreation or his designee.

"Formal hearing" means agency processes other than those informational or factual inquiries of an informal nature provided in § 9-6.14:7.1 of the Administrative Process Act and includes only opportunity for private parties to submit factual proofs in evidential hearings as provided in § 9-6.14:8 of the Administrative Process Act.

"Locality particularly affected" means any locality which bears any identified disproportionate material impact which would not be experienced by other localities.

"Participatory approach" means a method for the use of (i) standing advisory committees, (ii) ad hoc advisory groups or panels, (iii) consultation with groups or individuals registering interest in working with the agency, or (iv) any combination thereof in the formation and development of regulations for agency consideration. When

an ad hoc advisory group is formed, the group shall include representatives of the regulated community and the general public. The decisions as to the membership of the group shall be at the discretion of the director.

"Person" means an individual, a corporation, a partnership, an association, a governmental body, a municipal corporation, or any other legal entity.

"Public hearing" means an informal proceeding, held in conjunction with the Notice of Public Comment and similar to that provided for in § 9-6.14:7.1 of the Administrative Process Act, to afford persons an opportunity to submit views and data relative to regulations on which a decision of the approving authority is pending.

"Public meeting" means an informal proceeding conducted by the agency in conjunction with the Notice of Intended Regulatory Action to afford persons an opportunity to submit comments relative to intended regulatory actions.

"Virginia law" means the provisions found in the Code of Virginia or the Virginia Acts of Assembly statutory law authorizing the approving authority, director, or agency to make regulations or decide cases or containing procedural requirements thereof.

B. Unless specifically defined in Virginia law or in this regulation, terms used shall have the meanings commonly ascribed to them.

§ 2. General.

A. The procedures in § 3 of this regulation shall be used for soliciting the input of interested persons in the initial formation and development, amendment or repeal of regulations in accordance with the Administrative Process Act. This regulation does not apply to regulations exempted from the provisions of the Administrative Process Act § 9-6.14:1 A and B or excluded from the operation of Article 2 of the Administrative Process Act § 9-6.14:4.1 C.

B. At the discretion of the approving authority, the procedures in § 3 may be supplemented to provide additional public participation in the regulation adoption process or as necessary to meet federal requirements.

C. B. The failure of any person to receive any notice or copies of any documents provided under these guidelines shall not affect the validity of any regulation otherwise adopted in accordance with this regulation.

D. C. Any person may petition the approving authority for the adoption, amendment or repeal of a regulation. The petition, at a minimum, shall contain the following information:

1. Name of petitioner;

2. Petitioner's mailing address and telephone number;

3. Petitioner's interest in the proposed action;

4. Recommended regulation or addition, deletion or amendment to a specific regulation or regulations;

5. Statement of need and justification for the proposed action;

6. Statement of impact on the petitioner and other affected persons; and

7. Supporting documents, as applicable.

The approving authority shall provide a written response to such petition within 180 days from the date the petition was received.

§ 3. Public participation procedures.

A. The agency shall establish and maintain a list or lists consisting of persons expressing an interest in the adoption, amendment or repeal of regulations. Any person wishing to be placed on any list may do so by writing the agency. In addition, the agency, at its discretion, may add to any list any person, organization or publication it believes will be interested in participating in the promulgation of regulations. Individuals and organizations may be periodically requested to indicate their desire to continue to receive documents or be deleted from a list. Individuals and organizations may be deleted from any list at the request of the individual or organization, or at the discretion of the agency when mail is returned as undeliverable.

B. Whenever the approving authority so directs, the agency may commence the regulation adoption process and proceed to draft a proposal according to these procedures.

C. The agency shall form an ad hoc advisory group or utilize a standing advisory committee to assist in the drafting and formation of the proposal unless the director as the approving authority specifically authorizes the agency to proceed without utilizing an ad hoc advisory group or standing advisory committee. When an ad hoc advisory group is formed, such ad hoc advisory group shall include representatives of the regulated community and the general public. The director shall use the participatory approach to assist in the development of the proposal or use one of the following alternatives:

1. Proceed without using the participatory approach if the approving authority specifically authorizes the director to proceed without using the participatory approach.

2. Include in the Notice of Intended Regulatory Action (NOIRA) a statement inviting comment on whether the director should use the participatory approach to assist

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the agency in the development of the proposal. If the director receives written responses from at least five persons during the associated comment period indicating that the director should use the participatory approach, the director shall use the participatory approach requested. Should different approaches be requested, the director shall determine the specific approach to be utilized.

D. The agency shall issue a notice of intended regulatory action (NOIRA) whenever it considers the adoption, amendment or repeal of any regulation.

1. The NOIRA shall include, at least, the following:

a. A description of the subject matter of the planned regulation.

b. A description of the intent of the planned regulation.

c. A brief statement as to the need for regulatory action.

d. A brief description of alternatives available, if any, to meet the need.

e. A request for comments on the intended regulatory action, to include any ideas to assist the agency in the drafting and formation of any proposed regulation developed pursuant to the NOIRA development of any proposal.

f. A request for comments on the costs and benefits of the stated alternatives or other alternatives.

g. A statement of the director's intent to hold at least one public hearing on the proposed regulation after it is published in The Virginia Register of Regulations.

h. A statement inviting comment on whether the director should use the participatory approach to assist the agency in the development of any proposal. Including this statement shall only be required when the director makes a decision to pursue the alternative provided in subdivision C 2 of this section.

2. The agency shall hold at least one public meeting whenever it considers the adoption, amendment or repeal of any regulation unless the director as the approving authority specifically authorizes the agency to proceed without holding a public meeting.

In those cases where a public meeting(s) will be held, the NOIRA shall also include the date, not to be less than 30 days after publication in The Virginia Register of Regulations, time and place of the public meeting(s).

3. The public comment period for NOIRAs under this section shall be no less than 30 days after publication in The Virginia Register of Regulations.

E. The agency shall disseminate the NOIRA to the public via the following:

1. Distribution to the Registrar of Regulations for publication in The Virginia Register of Regulations.

2. Distribution by mail to persons on the list(s) established under subsection A of this section.

F. After consideration of public input, the agency may prepare complete the draft proposed regulation and any supporting documentation required for review. If an ad hoc advisory group has been established the participatory approach is being used, the draft regulation shall be developed in consultation with such group the participants. A summary or copies of the comments received in response to the NOIRA shall be distributed to the ad hoc advisory group participants during the development of the draft regulation. This summary or copies of the comments received in response to the NOIRA shall also be distributed to the approving authority.

G. Upon approval of the draft proposed regulation by the approving authority, the agency shall publish a Notice of Public Comment (NOPC) and the proposal for public comment.

H. The NOPC shall include, at least, the following:

1. The notice of the opportunity to comment on the proposed regulation, location of where copies of the draft may be obtained and name, address and telephone number of the individual to contact for further information about the proposed regulation.

2. A description of provisions of the proposed regulation which are more restrictive than applicable federal requirements, together with the reason why the more restrictive provisions are needed.

3. 2. A request for comments on the costs and benefits of the proposal.

3. The identity of any locality particularly affected by the proposed regulation.

4. A statement that an analysis of the following has been conducted by the agency and is available to the public upon request:

a. A statement of purpose: why the regulation is proposed and the desired end result or objective of the regulation the rationale or justification for the new provisions of the regulation, from the standpoint of the public's health, safety or welfare.

b. A statement of estimated impact:

(1) ~~Number~~ Projected number and types of regulated entities or persons affected.

(2) Projected cost, expressed as a dollar figure or range, to regulated entities (and to the public, if applicable) for implementation and compliance. In those instances where ~~an~~ the agency is unable to quantify projected costs, it shall offer qualitative data, if possible, to help define the impact of the regulation. Such qualitative data shall include, if possible, an example or examples of the impact of the proposed regulation on a typical member or members of the regulated community.

(3) Projected cost to the agency for implementation and enforcement.

(4) The beneficial impact the regulation is designed to produce.

c. An explanation of need for the proposed regulation and potential consequences that may result in the absence of the regulation.

d. An estimate of the impact of the proposed regulation upon small businesses as defined in § 9-199 of the Code of Virginia or organizations in Virginia.

e. A description of provisions of the proposed regulation which are more restrictive than applicable federal requirements, together with the reason why the more restrictive provisions are needed.

e. f. A discussion of alternative approaches that were considered to meet the need the proposed regulation addresses, and a statement as to whether the agency believes that the proposed regulation is the least burdensome alternative to the regulated community that fully meets the stated purpose of the proposed regulation.

f. g. A schedule setting forth when, after the effective date of the regulation, the agency will evaluate it for effectiveness and continued need.

5. The date, time and place of at least one public hearing held in accordance with § 9-6.14:7.1 to receive comments on the proposed regulation. ~~(In those cases where the agency elects to conduct an evidential hearing, the notice shall indicate that the evidential hearing will be held in accordance with § 9-6.14:8.)~~ The public hearing(s) may be held at any time during the public comment period and, whenever practicable, no less than 10 15 days prior to the close of the public comment period. The public hearing(s) may be held in such location(s) as the agency determines will best facilitate input from interested persons. *In those cases where the agency elects to conduct a formal hearing, the notice shall indicate that the formal*

hearing will be held in accordance with § 9-6.14:8 of the Administrative Process Act.

I. The public comment period shall close no less than 60 days after publication of the NOPC in The Virginia Register of Regulations.

J. The agency shall disseminate the NOPC to the public via the following:

1. Distribution to the Registrar of Regulations for:

a. Publication in The Virginia Register of Regulations.

b. Publication in a newspaper of general circulation published at the state capital and such other newspapers as the agency may deem appropriate.

2. Distribution by mail to persons on the list(s) established under subsection A of this section.

K. The agency shall prepare a summary of comments received in response to the NOPC and the agency's response to the comments received. *The agency shall send a draft of the summary of comments to all public commenters on the proposed regulation at least five days before final adoption of the regulation.* The agency shall submit the summary and agency response and, if requested, submit the full comments to the approving authority. The summary, the agency response, and the comments shall become a part of the agency file and after final action on the regulation by the director as the approving authority, made available, upon request, to interested persons.

L. If the director as the approving authority determines that the process to adopt, amend or repeal any regulation should be terminated after approval of the draft proposed regulation, the director shall state in writing a rationale for the withdrawal of the proposed regulation.

M. Completion of the remaining steps in the adoption process shall be carried out in accordance with the Administrative Process Act.

§ 4. Transition.

A. All regulatory actions for which a NOIRA has been published in The Virginia Register of Regulations prior to December 30, 1992; [*the effective date of this regulation June 29, 1994,*] shall be processed in accordance with the VR 215-01-00. emergency amendments to VR 217-00-00 Regulatory Public Participation Guidelines.

B. *This regulation [; when effective,] shall supersede and repeal emergency amendments to VR 217-00-00 Regulatory Public Participation Procedures which became effective June 30, 1993.* All regulatory actions for which a NOIRA has not been published in The Virginia Register of Regulations prior to December 30, 1992; [*the effective*

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date of this regulation June 29, 1994,] shall be processed in accordance with this regulation (VR 217-00-00. Regulatory Public Participation Procedures).

VA.R. Doc. No. R94-960; Filed May 10, 1994, 4:30 p.m.

DEPARTMENT OF CORRECTIONS (STATE BOARD OF)

Title of Regulation: VR 230-01-001. Public Participation Guidelines.

Statutory Authority: §§ 9-6.14:7.1 and 53.1-5 of the Code of Virginia.

Effective Date: July 1, 1994.

Summary:

These regulations outline how the Board of Corrections plans to ensure public participation in the formation and development of regulations as required in the Administrative Process Act. No changes were made to the proposed regulations.

Summary of Public Comment and Agency Response: No public comment was received by the promulgating agency.

Agency Contact: Copies of the regulation may be obtained from Amy Miller, Agency Regulatory Coordinator, Department of Corrections, 6900 Atmore Drive, Richmond, VA 23225, telephone (804) 674-3262.

VR 230-01-001. Public Participation Guidelines.

PART I. GENERAL PROVISIONS.

§ 1.1. Definitions.

The following words and terms, when used in these regulations, shall have the following meaning, unless the context clearly indicates otherwise:

"Agency" means any authority, instrumentality, officers of the Virginia Department of Corrections, and members of the Virginia Board of Corrections, or other unit of the state government empowered by the basic laws to make regulations or decide cases.

"Agency regulatory coordinator" means the individual appointed by the director to provide technical assistance to the operating units and to coordinate regulations.

"Basic law" or "basic laws" means provisions of the Constitution and statutes of the Commonwealth of Virginia authorizing an agency to make regulations or decide cases or containing procedural requirements thereof.

"Board" means the Virginia Board of Corrections.

"Department" means the Virginia Department of Corrections.

"Director" means the Director of the Virginia Department of Corrections.

"Operating unit" means the offices of the director, deputy directors, administrators or other offices within the department that will develop or draft a regulation. Only the board may promulgate a regulation.

"Rule" or "regulation" means any statement of general application, having the force of law, affecting the rights or conduct of any person, promulgated by an agency in accordance with the authority conferred on it by applicable basic laws. Exemptions to this requirement are those listed in § 9-6.14:4.1 of the Code of Virginia or as determined by the Attorney General's office.

§ 1.2. Authority.

Chapter 1.1:1 of Title 9 of the Code of Virginia, deals with the promulgation of rules and regulations. Specifically, § 9-6.14:7.1 directs agencies of the Commonwealth to develop public participation guidelines for soliciting the input of interested parties in the formation and development of regulations. Section 53.1-5 of the Code of Virginia empowers the Board of Corrections to make, adopt and promulgate rules and regulations.

§ 1.3. Purpose.

These guidelines are designed to provide consistent, written procedures that will ensure input from interested parties during the development, review and final stages of the regulatory process.

§ 1.4. Administration.

A. The board has the responsibility for promulgating regulations pertaining to public input in the regulatory process.

B. The director is the chief executive officer of the Department of Corrections and is responsible for implementing the standards and goals of the board.

§ 1.5. Application of regulations.

These regulations have general application throughout the Commonwealth.

§ 1.6. Effective date: October 1, 1989.

§ 1.7. § 1.6. Application of the Administrative Process Act.

The provisions of the Virginia Administrative Process Act, which is codified as Chapter 1.1:1 of Title 9 of the Code of Virginia, shall govern the adoption, amendment, modification, and revision of these regulations, and the conduct of all proceedings and appeals. All hearings on

such regulations shall be conducted in accordance with § 9-6.14:7.1 of the Code of Virginia .

PART II. PUBLIC PARTICIPATION.

§ 2.1. Identification of interested parties.

Each operating unit within the department which is responsible for rule making shall develop and maintain a current list of those persons, organizations, and agencies that have demonstrated an interest in specific program regulations in the past through written comments or attendance at public hearings.

§ 2.2. Notification of interested parties.

A. Individual mailings.

When an operating unit of the department determines that specific regulations need to be developed or substantially modified, the operating unit shall so notify by mail the individuals, organizations, and agencies identified as interested parties in § 2.1 of these regulations. This notice shall invite those interested in providing input to notify the agency of their interest. The notice shall include the title of the regulation to be developed or modified; the operating unit contact person, mailing address, telephone number; and the date by which a notice of a desire to comment must be received. In addition, known parties having interest and expertise will be advised through a special mailing of the agency's desire to develop a regulation and will be invited to assist the operating unit in developing the regulation or in providing input.

B. Notice of ~~intent~~ Intended Regulatory Action .

1. When an operating unit of the department determines that specific regulations that are covered by the Administrative Process Act need to be developed or substantially modified, the operating unit shall ~~publish provide~~ a ~~notice of intent in The Virginia Register of Regulations~~ Notice of Intended Regulatory Action to the Registrar of Regulations .

2. This notice will invite those interested in providing input to notify the operating unit of their interest. The notice will include the title of the regulation to be developed or modified; *the subject matter and intent of the planned regulation; whether or not the agency plans to hold a public hearing on the regulation after it is published*; the operating unit contact person, mailing address, telephone number; and the date by which a notice of a desire to comment must be received. All notices shall be coordinated through the agency regulatory coordinator who will forward them for publication.

3. *At least 30 days shall be provided for public comment after publication of the Notice of Intended Regulatory Action. The agency shall not file proposed*

regulations with the Registrar until the public comment period on the Notice of Intended Regulatory Action has closed.

4. Any person may petition the agency to request the agency to develop a new regulation or amend an existing regulation. The agency shall receive, consider, and respond to the petition in writing within 180 days.

5. If the agency states in the Notice of Intended Regulatory Action that it does not plan to hold a hearing on the proposed regulation, then no public hearing is required unless, prior to completion of the comment period specified in the Notice of Intended Regulatory Action, the Governor directs that the agency hold a public hearing, or the agency receives requests for a public hearing from at least 25 people.

§ 2.3. Solicitation of input from interested parties ; advisory panels; other comments .

A. Advisory panels.

A. Whenever an operating unit proposes to develop or substantially modify a regulation, it may create an advisory panel to assist in this development or modification. Advisory panels shall be established on an ad hoc basis.

1. Members of advisory panels shall consist of a balanced representation of individuals and representatives of organization and agencies identified in § 2.1 of these regulations as interested and who have expressed a desire to comment on new or modified regulations in the developmental process. Each panel shall consist of no less than three members.

2. Individual panels shall establish their own operating procedure, but in no case will a panel meet less than twice. All comments on proposed regulations shall be documented by the operating unit and a response developed for each comment.

B. Other comments.

B. All persons, organizations, and agencies that respond to the individual mailings and the notice of intent shall be provided an opportunity to examine regulations in their developmental stage and to provide written comments on these regulations to the operating unit. The operating unit shall document the receipt of these comments and respond to each commentor. The operating unit shall consider all input received as a result of responses to notifications mailed to interested parties as listed in § 2.2 of these regulations in formulating and drafting proposed regulations.

§ 2.4. Administrative Process Act procedures.

After regulations have been developed according to

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these guidelines, they shall be submitted for public comment under § 9-6.14:7.1 of the Code of Virginia.

V.A.R. Doc. No. R94-957; Filed May 6, 1994, 3:34 p.m.

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Title of Regulation: VR 230-30-005. Guide for Minimum Standards in Planning, Design and Construction of Jail Facilities (REPEALED).

Statutory Authority: §§ 53.1-5, 53.1-68, and 53.1-80 through 53.1-82.3 of the Code of Virginia.

Effective Date: July 1, 1994.

Summary:

The Board of Corrections has repealed "Guide for Minimum Standards in Planning, Design and Construction of Jail Facilities." The provisions of these regulations are included instead in VR 230-30-005:1 Standards for Planning, Design, Construction and Reimbursement of Local Correctional Facilities, and fulfill the Board of Corrections' obligation to establish minimum standards for the construction, equipment, administration and operation of local correctional facilities, along with regulations establishing criteria to assess need, establish priorities, and evaluate requests for reimbursement of construction costs to ensure fair and equitable distribution of state funds provided.

Summary of Public Comment and Agency Response: No public comment was received by the promulgating agency.

Agency Contact: Amy Miller, Regulatory Coordinator, Department of Corrections, 6900 Atmore Drive, Richmond, VA 23225, telephone (804) 674-3262.

V.A.R. Doc. No. R94-990; Filed May 11, 1994, 11:16 a.m.

* * * * *

EDITOR'S NOTICE: The final regulation entitled, "VR 230-30-005:1, Standards for Planning, Design, Construction and Reimbursement of Local Correctional Facilities" filed by the Department of Corrections is not being published due to the length. However, in accordance with § 9-6.14:22 of the Code of Virginia a summary is being published in lieu of the full text. The full text of the regulation is available for public inspection at the Office of the Registrar of Regulations, Virginia Code Commission, 910 Capitol Square, Room 262, Richmond, VA 23219, and at the Department of Corrections, 6900 Atmore Drive, Richmond, VA 23225. Copies of the regulations may be obtained from Amy Miller, Regulatory Coordinator, Department of Corrections, 6900 Atmore Drive, Richmond, VA 23225, telephone (804) 674-3262.

Title of Regulation: VR 230-30-005:1. Standards for Planning, Design, Construction and Reimbursement of Local Correctional Facilities.

Statutory Authority: §§ 53.1-5, 53.1-68, and 53.1-80 through 53.1-82.3 of the Code of Virginia.

Effective Date: July 1, 1994.

Summary:

The Board of Corrections has adopted the regulations, "Standards for Planning, Design, Construction and Reimbursement of Local Correctional Facilities" in order to replace the emergency regulations which became effective July 1, 1993.

The provisions of the regulations fulfill the Board of Corrections' obligation to establish minimum standards for the construction, equipment, administration and operation of local correctional facilities, along with regulations establishing criteria to assess need, establish priorities, and evaluate requests for reimbursement of construction costs to ensure fair and equitable distribution of state funds provided.

These regulations supersede VR 230-30-008, "Regulations for State Reimbursement of Local Correctional Facility Construction Costs" and VR 230-30-005, "Guide for Minimum Standards in Design and Construction of Jail Facilities."

The changes since the proposed version include deleting any implications that the regulations pertain to local alternative sanction programs, deleting requirements that facilities maintain space for juveniles, clarifying the reimbursement process, and clarifying the definition of "reviewing authority." Other substantive changes include clarifying and strengthening certain construction requirements dealing with mechanical, plumbing, and electrical fixtures. Finally, many technical changes were made to lend to the clarity and organization of the document.

Summary of Public Comment and Agency Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the Office of the Registrar of Regulations.

Agency Contact: Copies of the regulation may be obtained from Amy Miller, Regulatory Coordinator, Department of Corrections, 6900 Atmore Drive, Richmond, VA 23225, telephone (804) 674-3262. There may be a charge for copies.

V.A.R. Doc. No. R94-988; Filed May 11, 1994, 11:15 a.m.

* * * * *

Title of Regulation: VR 230-30-008. Regulations for State Reimbursement of Local Correctional Facility Construction Costs (REPEALED).

Statutory Authority: §§ 53.1-5, 53.1-68, and 53.1-80 through

53.1-82.1 of the Code of Virginia.

Effective Date: July 1, 1994.

Summary:

The Board of Corrections has repealed "Regulations for State Reimbursement of Local Correctional Facility Construction Costs." The provisions of these regulations will be included instead in "VR 230-30-005:1 Standards for Planning, Design, Construction and Reimbursement of Local Correctional Facilities" being finalized in this issue of The Virginia Register. The provisions of VR 230-30-005:1 fulfill the Board of Corrections' obligation to establish minimum standards for the construction, equipment, administration and operation of local correctional facilities, along with regulations establishing criteria to assess need, establish priorities, and evaluate requests for reimbursement of construction costs to ensure fair and equitable distribution of state funds provided.

Summary of Public Comment and Agency Response: No public comment was received by the promulgating agency.

Agency Contact: Amy Miller, Regulatory Coordinator, Department of Corrections, 6900 Atmore Drive, Richmond, VA 23225, telephone (804) 672-3262.

V.A.R. Doc. No. R94-989; Filed May 11, 1994, 11:15 a.m.

DEPARTMENT OF LABOR AND INDUSTRY

Title of Regulation: VR 425-01-100. Public Participation Guidelines.

Statutory Authority: §§ 9-1.14:7.1 and 40.1-6 of the Code of Virginia.

Effective Date: June 30, 1994.

Summary:

The Administrative Process Act (APA) requires each agency to develop, adopt and use Public Participation Guidelines for soliciting comments from interested parties when developing, revising, or repealing regulations. Legislation enacted by the 1993 General Assembly amended the APA by adding additional provisions to be included in agency Public Participation Guidelines.

Public Participation Guidelines were adopted by the Department of Labor and Industry's Commissioner on September 19, 1984. Emergency Public Participation Guidelines which included the new requirements were adopted by the commissioner June 24, 1993, and were effective June 30, 1993, through June 29, 1994.

The Public Participation Guidelines of the Department of Labor and Industry set out procedures to be followed by the department which ensure that the public and all parties interested in regulations adopted by the commissioner have a full and fair opportunity to participate at every stage in the development or revision of the regulations. The regulation has been developed to ensure compliance with the Administrative Process Act and any executive directives concerning regulations.

The regulation sets forth processes to identify interested groups, to involve the public in the formulation of regulations, to solicit and use public comments and suggestions, and to draft and adopt regulations. It also defines the role of advisory groups and the use of open meetings.

Summary of Public Comment and Agency Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the Office of the Registrar of Regulations.

Agency Contact: Copies of the regulation may be obtained from Bonnie H. Robinson, Department of Labor and Industry, 13 South 13th Street, Richmond, VA 23219, telephone (804) 371-2631. There may be a charge for copies.

VR 425-01-100. Public Participation Guidelines.

PART I. DEFINITIONS.

§ 1.1. Definitions.

The following words and terms, when used in these regulations, shall have the following meaning, unless the context clearly indicates otherwise:

"Ad hoc advisory group" means a task force to develop a new regulation, or review current regulations, or revise current regulations, or advise the commissioner on particular issues under consideration for regulation.

"Administrative Process Act" means Chapter 1.1:1 (§ 9-6.14:1 et seq.) of Title 9 of the Code of Virginia.

"Commissioner" means the Commissioner of Labor and Industry or his designee.

"Department" means the Virginia Department of Labor and Industry.

"Locality particularly affected" means any locality which bears any identified disproportionate material impact which would not be experienced by other localities.

"Open meeting" means an informal meeting to provide an opportunity for the commissioner or his designee to

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hear information, receive views and comments, and to answer questions presented by the public on a particular issue or regulation under consideration by the department. It is a meeting to facilitate the informal exchange of information and may be held prior to or during the regulation promulgation process.

"Public hearing" means an informational proceeding conducted pursuant to § 9-6.14:7.1 of the Code of Virginia.

"Regulation" means any statement of general application, having the force of law, affecting the rights or conduct of any person, promulgated by the commissioner in accordance with the authority conferred upon him by applicable basic law.

"Secretary" means the Secretary of Commerce and Trade or his designee.

PART II. GENERAL INFORMATION.

§ 2.1. Applicability.

These guidelines shall apply to all regulations subject to the Administrative Process Act which are administered by the Commissioner of Labor and Industry, hereafter referred to as commissioner. They shall not apply to regulations adopted on an emergency basis. This regulation does not apply to regulations exempted from the provisions of the Administrative Process Act (§ 9-6.14:4.1 A and B) or excluded from the operation of Article 2 of the Administrative Process Act (§ 9-6.14:4.1 C).

§ 2.2. Purpose.

The purpose of these guidelines is to ensure that the public and all parties interested in the regulations have a full and fair opportunity to participate at every stage in the development or revision of the regulations.

The failure of any person to receive any notice or copies of any documents provided under these guidelines shall not affect the validity of any regulation otherwise adopted in accordance with this regulation.

At the discretion of the commissioner, the procedures in Part III may be supplemented to provide additional public participation in the regulation adoption process or as necessary to meet federal requirements.

§ 2.3. Identification of interested persons and groups.

The major groups interested in the regulatory process of the commissioner are:

1. Business and labor associations and organizations such as the Virginia Manufacturers Association and the Virginia State AFL-CIO;
2. Persons, groups, businesses, industries, and

employees affected by the specific regulation who have previously expressed an interest by writing or participating in public hearings; and

3. Persons or groups who have asked to be placed on a mailing list.

§ 2.4. Public involvement with formulation of regulations.

A. The commissioner shall accept petitions to develop a new regulation or amend an existing regulation from any member of the public. The commissioner shall consider the petition and provide a response within 180 days.

B. The petition, at a minimum, shall contain the following information:

1. Name, mailing address and telephone number of petitioner;
2. Petitioner's interest in the proposed action;
3. Recommended regulation or addition, deletion or amendment to a specific regulation;
4. Statement of need and justification for the proposed action;
5. Statement of impact on the petitioner and other affected persons; and
6. Supporting documents, as applicable.

PART III. PUBLIC PARTICIPATION PROCEDURES.

§ 3.1. Advisory groups and consultation.

A. The commissioner may form a standing or ad hoc advisory group to make recommendations on a proposed regulation. When an ad hoc advisory group is formed, it shall include representatives from the interested persons or groups identified in § 2.3. The membership of any ad hoc advisory group shall be selected by the commissioner.

B. Ad hoc advisory groups or consultation with groups or individuals will be used when the regulation proposed is unique to Virginia or more stringent than existing federal regulations.

C. Ad hoc advisory groups or consultation with groups or individuals may be used when:

1. The proposed regulation is of wide general impact;
2. The proposed regulation is of wide general interest to the public;
3. The subject of the regulation has not been regulated previously by the department;

4. The department determines this is the most effective method to develop the regulation; or

5. The department determines additional technical expertise and knowledge would be beneficial in developing the regulation.

§ 3.2. Open meetings.

The commissioner may schedule an open meeting or meetings to provide information and to receive views and comments and answer questions from the public. The meeting(s) will normally be held at locations throughout the Commonwealth, but if the proposed regulation will apply only to a particular area of the state, it will be held in the affected area. These meetings may be held prior to the beginning of the formal regulatory process or during the Notice of Intended Regulatory Action period or during the 60-day comment period on proposed regulations and will be in addition to any public hearing.

§ 3.3. Notice of Intended Regulatory Action (NOIRA).

A. The department will identify persons or groups, as referred to in § 2.3, interested in the development of the regulation and assemble the appropriate mailing list.

B. The department shall issue a NOIRA whenever it intends to consider the development, amendment or repeal of any regulation. The NOIRA will include:

1. Subject of the proposed regulation.
2. Identification of the persons or groups affected.
3. Summary of the purpose of the proposed regulation and the issues involved.
4. Listing of applicable laws or regulations, and locations where these documents can be reviewed or obtained.
5. Explanation of federal requirements for adoption and specific obligations of the commissioner, if applicable.
6. Request for comments from interested parties and deadline for receipt of the written comments.
7. Notification of time and place of open meeting(s), if the commissioner intends to hold open meetings.
8. Name, address and telephone number of staff person to be contacted for further information.
9. Statement that the commissioner intends to hold a public hearing on the proposed regulation after it is published.

C. If appropriate, the commissioner will appoint an advisory group as outlined in § 3.1.

D. The NOIRA will be disseminated to the public via:

1. Distribution by mail, facsimile or other appropriate delivery method to persons on the appropriate mailing list.
2. Publication in The Virginia Register of Regulations.
3. Publication in a newspaper of statewide circulation.
4. Publication in newspaper(s) in localities particularly affected by the regulation. The localities particularly affected have been identified by the department.

§ 3.4. Proposed regulations.

A. After consideration of public comment, the department may prepare a proposed draft regulation and any necessary documentation required for review. If an ad hoc advisory group has been established, the draft regulation shall be developed in consultation with such group.

B. The commissioner will present the proposed draft to the secretary's office for review and concurrence prior to the beginning of the 60-day public comment period.

C. The department will submit the proposed regulation to a 60-day public hearing/comment period by forwarding the following documents to the Registrar of Regulations by the established submission date for the desired date of publication in The Virginia Register and the beginning of the 60-day comment period:

1. Notice of public hearing/comment period, which will contain the following:
 - a. The date, time and place of the public hearing. (Public hearing is defined in this regulation.)
 - b. The legal authority of the commissioner to act.
 - c. The name, address and telephone number of an individual to contact for further information and where to submit written comments.
2. Full text of the regulation.
3. Summary of the regulation.
4. Statement of the basis of the regulation, defined as the statutory authority for promulgating the regulation, including an identification of the section number and a brief statement relating the content of the statutory authority to the specific regulation proposed.
5. Statement of the purpose of the regulation, defined as the rationale or justification for the provisions of a new regulation or changes to an existing regulation, from the standpoint of the public's health, safety or welfare.

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6. Statement of the substance of the regulation, defined as the identification and explanation of the key provisions of the regulation.

7. Statement of the issues of the regulations, defined as the primary advantages and disadvantages for the public, and as applicable for the department or the state, of implementing the new or amended regulatory provisions.

8. Statement of the estimated impact, defined as the projected number of persons affected, the projected costs, expressed as a dollar figure or range, for the implementation and compliance with the new regulation or amendments, and the identity of any localities particularly affected by the regulation. The estimated impact shall represent the commissioner's best estimate for the purposes of public review and comment, but the accuracy of the estimate shall in no way affect the validity of the regulation.

9. A copy of the written assurance from the Office of the Attorney General which states that the commissioner has the statutory authority to issue the proposed regulation.

10. An explanation of how clarity and simplicity were assured in drafting the regulations.

11. A statement describing the alternative approaches that were considered to meet the need the proposed regulations address, and assurance that the proposed regulations are the least burdensome available alternative.

12. A schedule setting forth when, after the effective date of the regulation, the commissioner will evaluate it for effectiveness and continued need.

D. Concurrently with the preceding step, the commissioner will submit required documentation to the Governor's office, the Department of Planning and Budget, and the Office of the Secretary of Commerce and Trade.

E. Upon receipt of the proposed regulation and appropriate documentation, the Registrar of Regulations will publish the summary of the regulation and the public hearing notice in The Virginia Register and in a Richmond area newspaper of general circulation. If applicable, the department will request that the Registrar publish the notice in newspapers in other areas of the state. The department will mail a copy of the notice to persons and groups on the appropriate mailing list.

F. During the public comment period, the regulation will be available for review concurrently by the following:

1. The public,
2. The Governor,

3. The General Assembly,

4. The Secretary of Commerce and Trade, and

5. The Attorney General

§ 3.5. Completion of the adoption process.

A. The department shall prepare a summary of the oral and written comments received during the 60-day public comment period and the department's response to the comments. A draft of the department's summary shall be sent to all parties who commented on the proposed regulation. The summary shall be sent at least five days before final adoption of the regulation.

B. At the end of the 60-day public comment period, the department shall prepare the final proposed regulation.

C. The department shall submit the final regulation to the Registrar of Regulations for publication in The Virginia Register at least 30 days prior to the effective date of the regulation.

D. The following documents shall be sent to the Registrar's Office. Concurrently, these documents shall be sent to the Governor's Office, the Department of Planning and Budget, and the Office of the Secretary of Commerce and Trade.

1. A copy of the final regulation.
2. A current summary and statement as to the basis, purpose, substance, issues, and impact of the regulation.
3. The summary of the oral and written comments received during the 60-day public comment period and the department's response to the comments.

VA.R. Doc. No. R94-969; Filed May 11, 1994, 10:49 a.m.

Department Of Labor And Industry; Safety And Health Codes Board; Apprenticeship Council

Title of Regulation: VR 425-01-68. Public Participation Guidelines (REPEALED).

Statutory Authority: §§ 9-6.14:7.1, 40.1-6, 40.1-22 and 40.1-117 of the Code of Virginia.

Effective Date: June 30, 1994.

Summary:

Public participation guidelines were adopted by the Department of Labor and Industry, the Safety and Health Codes Board, and the Apprenticeship Council on September 19, 1984. Legislative action by the 1993 General Assembly amended the Administrative Process

Act by adding requirements for public participation in the regulatory process.

Emergency Public Participation Guidelines which included the additional provisions required by legislation enacted by the 1993 General Assembly were adopted by the department, board and council prior to July 1993 and are in effect until June 29, 1994. New guidelines for the department, the Safety and Health Codes Board and the Apprenticeship Council have been developed. Therefore, this regulation is no longer necessary and has been repealed.

Summary of Public Comment and Agency Response: No public comment was received by the promulgating agency.

Agency Contact: Bonnie H. Robinson, Administrative Staff Specialist, Department of Labor and Industry, 13 South 13th Street, Richmond, VA 23219, telephone (804) 371-2631.

VA.R. Doc. No. R94-970; Filed May 11, 1994, 10:49 a.m.

Virginia Apprenticeship Council

Title of Regulation: VR 425-01-102. Public Participation Guidelines.

Statutory Authority: §§ 9-6.14:7.1 and 40.1-117 of the Code of Virginia.

Effective Date: June 30, 1994.

Summary:

The Administrative Process Act (APA) requires each agency to develop, adopt and use Public Participation Guidelines for soliciting comments from interested parties when developing, revising, or repealing regulations. Legislation enacted by the 1993 General Assembly amended the APA by adding additional provisions to be included in agency Public Participation Guidelines.

Public Participation Guidelines were adopted by the Apprenticeship Council on September 19, 1984. Emergency Public Participation Guidelines which included the new requirements were adopted by the council June 28, 1993, and were effective June 30, 1993, through June 29, 1994.

The Public Participation Guidelines of the Virginia Apprenticeship Council (council) set out procedures to be followed by the council and the Department of Labor and Industry which ensure that the public and all parties interested in regulations adopted by the council have a full and fair opportunity to participate at every stage.

The regulation sets forth processes to identify interested groups, to involve the public in the

formulation of regulations, to solicit and use public comments and suggestions, and to draft and adopt regulations. It also defines the role of advisory groups and the use of open meetings.

Summary of Public Comment and Agency Response: No public comment was received by the promulgating agency.

Agency Contact: Copies of the regulation may be obtained from Bonnie H. Robinson, Administrative Staff Specialist, Department of Labor and Industry, 13 South 13th Street, Richmond, VA, 23219, telephone (804) 371-2631. There may be a charge for copies.

VR 425-01-102. Public Participation Guidelines.

PART I. DEFINITIONS.

§ 1.1. Definitions.

The following words and terms, when used in these regulations, shall have the following meaning, unless the context clearly indicates otherwise:

"Ad hoc advisory group" means a task force to develop a new regulation, or review current regulations, or revise current regulations, or advise the council on particular issues under consideration for regulation.

"Administrative Process Act" means Chapter 1.1:1 (§ 9-6.14:1 et seq.) of Title 9 of the Code of Virginia.

"Commissioner" means the Commissioner of Labor and Industry or his designee.

"Council" means the Virginia Apprenticeship Council.

"Department" means the Virginia Department of Labor and Industry.

"Open meeting" means an informal meeting to provide an opportunity for the council or their designee(s) to hear information, receive views and comments, and to answer questions presented by the public on a particular issue or regulation under consideration by the council. It is a meeting to facilitate the informal exchange of information and may be held prior to or during the regulation promulgation process.

"Public hearing" means an informational proceeding conducted pursuant to § 9-6.14:7.1 of the Code of Virginia.

"Regulation" means any statement of general application, having the force of law, affecting the rights or conduct of any person, promulgated by the council with the authority conferred upon it by applicable basic law.

"Secretary" means the Secretary of Commerce and Trade or his designee.

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PART II. GENERAL INFORMATION.

§ 2.1. Applicability.

These guidelines shall apply to all regulations subject to the Administrative Process Act which are adopted by the Apprenticeship Council and administered by the Commissioner of Labor and Industry. They shall not apply to regulations adopted on an emergency basis. This regulation shall not apply to regulations exempted from the provisions of the Administrative Process Act (§ 9-6.14:4.1 A and B) or excluded from the operation of Article 2 of the Administrative Process Act (§ 9-6.14:4.1 C).

§ 2.2. Purpose.

The purpose of these guidelines is to ensure that the public and all parties interested in the regulations have a full and fair opportunity to participate at every stage.

The failure of any person to receive any notice or copies of any documents provided under these guidelines shall not affect the validity of any regulation otherwise adopted in accordance with this regulation.

At the discretion of the council, the procedures in Part III may be supplemented to provide additional public participation in the regulation adoption process or as necessary to meet federal requirements.

§ 2.3. Identification of interested groups.

The major groups interested in the regulatory process of the council are:

1. Business and labor associations and organizations such as the Virginia Manufacturers Association and the Virginia State AFL-CIO;
2. Persons, groups, businesses, industries, and employees affected by the specific regulation who have previously expressed an interest by writing or participating in public hearings; and
3. Persons or groups who have asked to be placed on a mailing list.

§ 2.4. Public involvement with formulation of regulations.

A. The council shall accept petitions to develop a new regulation or amend an existing regulation from any member of the public. The council shall consider the petition and provide a response within 180 days.

B. The petition, at a minimum, shall contain the following information:

1. Name, mailing address and telephone number of petitioner;

2. Petitioner's interest in the proposed action;

3. Recommended regulation or addition, deletion or amendment to a specific regulation;

4. Statement of need and justification for the proposed action;

5. Statement of impact on the petitioner and other affected persons; and

6. Supporting documents, as applicable.

PART III. PUBLIC PARTICIPATION PROCEDURES.

§ 3.1. Advisory groups and consultation.

A. The council may form a standing or ad hoc advisory group to make recommendations on a proposed regulation.

B. Ad hoc advisory groups or consultation with groups or individuals may be used when:

1. The proposed regulation is of wide general impact;
2. The proposed regulation is of wide general interest to the public;
3. The subject of the regulation has not been regulated previously by the council;
4. The council determines this is the most effective method to develop the regulation; or
5. The council determines additional technical expertise and knowledge would be beneficial in developing the regulation.

§ 3.2. Open meetings.

The council may schedule an open meeting or meetings to provide information and to receive views and comments and answer questions from the public. The meeting(s) will normally be held at locations throughout the Commonwealth, but if the proposed regulation will apply only to a particular area of the state, it will be held in the affected area. These meetings may be held prior to the beginning of the formal regulatory process or during the Notice of Intended Regulatory Action period or during the 60-day comment period on proposed regulations and will be in addition to any public hearing.

§ 3.3. Notice of Intended Regulatory Action (NOIRA).

A. The department will identify parties as referred to in § 2.3 interested in the development of the regulation and assemble the appropriate mailing list.

B. The council shall issue a NOIRA whenever it considers the adoption, amendment or repeal of any

regulation [- The NOIRA will include: subject to the Administrative Process Act (APA). The NOIRA will include all of the information which is required by the APA.

1. Subject of the proposed regulation.
2. Identification of the persons or groups affected.
3. Summary of the purpose of the proposed regulation and the issues involved.
4. Listing of applicable laws or regulations, and locations where these documents can be reviewed or obtained.
5. Explanation of federal requirements for adoption and specific obligations of the council, if applicable.
6. Request for comments from interested parties and deadline for receipt of the written comments.
7. Notification of time and place of open meeting(s), if the council intends to hold open meetings.
8. Name, address and telephone number of staff person to be contacted for further information.
9. Statement that the council intends to hold a public hearing on the proposed regulation after it is published.]

C. The council will appoint advisory or consultation groups in accordance with § 3.1, if appropriate.

D. The NOIRA will be disseminated to the public via:

1. Distribution by mail to persons on appropriate mailing list, including publications of interested groups.
2. Publication in The Virginia Register of Regulations.
3. Publication in newspaper of statewide circulation and in specific affected areas of the state, if applicable.

§ 3.4. Proposed regulations.

A. After consideration of public comment, the council may prepare a proposed draft regulation and any necessary documentation required for review. If an ad hoc advisory group has been established, the draft regulation shall be developed in consultation with such group.

[B. The commissioner at the direction of the council will present the proposed draft to the secretary's office for review and concurrence prior to the beginning of the 60-day public comment period.]

[C. B.] The council will submit the proposed regulation to a 60-day public hearing/comment period by forwarding the [following proposed regulation and all Administrative

Process Act required] documents to the Registrar of Regulations by the established submission date for the desired date of publication in The Virginia Register and the beginning of the 60-day comment period [: .

1. Notice of public hearing/comment period, which will contain the following:
 - a. The date, time and place of the hearing.
 - b. The legal authority of the council to act.
 - c. The name, address and telephone number of an individual to contact for further information and where to submit written comments.
2. Full text of the regulation.
3. Summary of the regulation.
4. Statement of the basis of the regulation, defined as the statutory authority for promulgating the regulation, including an identification of the section number and a brief statement relating the content of the statutory authority to the specific regulation proposed.
5. Statement of the purpose of the regulation, defined as the rationale or justification for the provisions of a new regulation or changes to an existing regulation, from the standpoint of the public's health, safety or welfare.
6. Statement of the substance of the regulation, defined as the identification and explanation of the key provisions of the regulation.
7. Statement of the issues of the regulations, defined as the primary advantages and disadvantages for the public, and as applicable for the department or the state, of implementing the new or amended regulatory provisions.
8. Statement of the estimated impact, defined as the projected number of persons affected, and the projected costs, expressed as a dollar figure or range, for the implementation and compliance with the new regulation or amendments. The estimated impact shall represent the council's best estimate for the purposes of public review and comment, but the accuracy of the estimate shall in no way affect the validity of the regulation.
9. A copy of the written assurance from the Office of the Attorney General which states that the council has the statutory authority to issue the proposed regulation.
10. An explanation of how clarity and simplicity were assured in drafting the regulations.
11. A statement describing the alternative approaches

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that were considered to meet the need the proposed regulations address, and assurance that the proposed regulations are the least burdensome available alternative.

12. A schedule setting forth when, after the effective date of the regulation, the council will evaluate it for effectiveness and continued need.]

[D. C.] Concurrently with the preceding step, the council will submit required documentation [to the Governor's office, the Department of Planning and Budget, and the Office of the Secretary of Commerce and Trade, and the proposed regulation for review by other agencies as required by Governor's directive.]

[E. D.] Upon receipt of the proposed regulation and appropriate documentation, the Registrar of Regulations will publish the summary of the regulation and the public hearing notice in The Virginia Register and in the Richmond area newspaper of general circulation. If requested, the Registrar will publish the notice in other selected areas of the state. A copy of the notice shall also be mailed to persons on the appropriate mailing list.

[F. During the public comment period, the regulation will be reviewed concurrently by the following:

1. The public;
2. The Governor;
3. The General Assembly;
4. The Secretary of Commerce and Trade; and
5. The Attorney General.]

§ 3.5. Completion of the adoption process.

A. The council shall prepare a summary of the oral and written comments received during the 60-day public comment period and the council's response to the comments. A draft of the council's summary shall be sent to all parties who commented on the proposed regulation. The summary shall be sent at least five days before final adoption of the regulation.

B. At the end of the 60-day public comment period, the council shall prepare the final proposed regulation.

C. The final regulation shall be submitted to the council for adoption.

D. The council shall submit the final regulation [with the Administrative Process Act required documentation] to the Registrar of Regulations for publication in The Virginia Register at least 30 days prior to the effective date of the regulation. [Concurrently, the final regulation and any other required documentation will be submitted for review by other agencies as required by Governor's directive.]

[E. The following documents shall be sent to the Registrar's Office. Concurrently, these documents shall be sent to the Governor's Office, the Department of Planning and Budget, and the Office of the Secretary of Commerce and Trade.

1. A copy of the final regulation.

2. A current summary and statement as to the basis, purpose, substance, issues, and impact of the regulation.

3. The summary of the oral and written comments received during the 60-day public comment period and the council's response to the comments.]

[F. E.] The remaining steps in the adoption process shall be carried out in accordance with the provisions of the Administrative Process Act and the Governor's Executive Order for review of proposed regulations.

V.A.R. Doc. No. R94-967; Filed May 11, 1994, 10:50 a.m.

Safety and Health Codes Board

REGISTRAR'S NOTICE: The following regulation filed by the Department of Labor and Industry is excluded from Article 2 of the Administrative Process Act in accordance with § 9-6.14:4.1 C 4(c) of the Code of Virginia, which excludes regulations that are necessary to meet the requirements of federal law or regulations, provided such regulations do not differ materially from those required by federal law or regulation. The Safety and Health Codes Board will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: VR 425-02-01. General Industry Standard for Hazard Communication (1910.1200).

Statutory Authority: § 40.1-22(5) of the Code of Virginia.

Effective Date: July 1, 1994.

Summary:

The amendment to the existing Hazard Communication Standard includes a number of minor changes and technical corrections to further clarify the requirements and thereby help ensure full compliance and achieve protection for employees. In general, the change adds and clarifies certain exemptions from labeling and other requirements; modifies and clarifies aspects of the written hazard communication program and labeling requirements; clarifies and slightly modifies the duties of distributors, manufacturers and importers to provide material safety data sheet (MSDSs) to employees; and clarifies certain provisions regarding MSDSs.

Note on Incorporation By Reference

Pursuant to § 9-6.18 of the Code of Virginia, the General Industry Standard for Hazard Communication (1910.1200) is declared a document generally available to the public and appropriate for incorporation by reference. For this reason the entire document will not be printed in The Virginia Register of Regulations. Copies of the document are available for inspection at the Department of Labor and Industry, 13 South 13th Street, Richmond, Virginia, and in the Office of the Registrar of Regulations, General Assembly Building, Capitol Square, Room 262, Richmond, Virginia.

On April 25, 1994, the Safety and Health Codes Board adopted an identical version of federal OSHA's amendment to the General Industry Standard for Hazard Communication, 29 CFR 1910.1200, as published in the Federal Register, Vol. 59, No. 27, pp. 6169-6184, Wednesday, February 9, 1994. The amendments as adopted are not set out.

When the regulations, as set forth in the General Industry Standard for Hazard Communication, § 1910.1200, are applied to the Commissioner of the Department of Labor and Industry or to Virginia employers, the following federal terms shall be considered to read as follows:

<u>Federal Terms</u>	<u>VOSH Equivalent</u>
29 CFR	VOSH Standard
Assistant Secretary	Commissioner of Labor and Industry
March 11, 1994	July 1, 1994

V.A.R. Doc. No. R94-947; Filed May 2, 1994, 10:49 a.m.



COMMONWEALTH of VIRGINIA

JOAN W. SMITH
REGISTRAR OF REGULATIONS

VIRGINIA CODE COMMISSION
General Assembly Building

510 CAPITOL STREET
RICHMOND, VIRGINIA 23219
(804) 786-2591

May 11, 1994

Mr. Linwood Saunders, Chairman
Virginia Safety and Health Codes Board
c/o Mr. John J. Cristanti, Director
Office of Enforcement Policy
The Department of Labor and Industry
13 South Thirteenth Street
Richmond, Virginia 23219

RE: VR 425-02-01 Amendment to General Industry Standard
for Hazard Communication, 1910.1200

Dear Mr. Saunders:

This will acknowledge receipt of the above-referenced regulations from the Department of Labor and Industry.

As required by § 9-6.14:4.1 C.4.(c) of the Code of Virginia, I have determined that these regulations are exempt from the operation of Article 2 of the Administrative Process Act, since they do not differ materially from those required by federal law.

Sincerely,

Joan W. Smith
Registrar of Regulations

JWS:jbc

Final Regulations

REGISTRAR'S NOTICE: The following regulation filed by the Department of Labor and Industry is excluded from Article 2 of the Administrative Process Act in accordance with § 9-6.14:4.1 C 4(c) of the Code of Virginia, which excludes regulations that are necessary to meet the requirements of federal law or regulations, provided such regulations do not differ materially from those required by federal law or regulation. The Safety and Health Codes Board will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: VR 425-02-03. Marine Terminals Standard for Hazard Communication (1917.28).

Statutory Authority: § 40.1-22(5) of the Code of Virginia.

Effective Date: July 1, 1994.

Summary:

The amendment to the existing Hazard Communication Standard includes a number of minor changes and technical corrections to further clarify the requirements and thereby help ensure full compliance and achieve protection for employees. In general, the change adds and clarifies certain exemptions from labeling and other requirements; modifies and clarifies aspects of the written hazard communication program and labeling requirements; clarifies and slightly modifies the duties of distributors, manufacturers and importers to provide material safety data sheet (MSDSs) to employees; and clarifies certain provisions regarding MSDSs.

Note on Incorporation By Reference

Pursuant to § 9-6.18 of the Code of Virginia, the Marine Terminals Standard for Hazard Communication (1917.28) is declared a document generally available to the public and appropriate for incorporation by reference. For this reason the entire document will not be printed in The Virginia Register of Regulations. Copies of the document are available for inspection at the Department of Labor and Industry, 13 South 13th Street, Richmond, Virginia, and in the Office of the Registrar of Regulations, General Assembly Building, Capitol Square, Room 262, Richmond, Virginia.

On April 25, 1994, the Safety and Health Codes Board adopted an identical version of federal OSHA's amendment to the Marine Terminals Standard for Hazard Communication, 29 CFR 1917.28, as published in the Federal Register, Vol. 59, No. 27, pp. 6169-6184, Wednesday, February 9, 1994. The amendments as adopted are not set out.

When the regulations, as set forth in the Marine Terminals Standard for Hazard Communication, § 1917.28, are applied to the Commissioner of the Department of Labor and Industry or to Virginia employers, the following federal terms shall be considered to read as follows:

Federal Terms

VOSH Equivalent

29 CFR VOSH Standard
Assistant Secretary Commissioner of Labor and Industry
March 11, 1994 July 1, 1994

V.A.R. Doc. No. R94-946; Filed May 2, 1994, 10:50 a.m.



COMMONWEALTH of VIRGINIA

JOAN W. SMITH
REGISTRAR OF REGULATIONS

VIRGINIA CODE COMMISSION
General Assembly Building

110 CAPITOL STREET
RICHMOND, VIRGINIA 23219
(804) 786-3591

May 11, 1994

Mr. Linwood Saunders, Chairman
Virginia Safety and Health Codes Board
c/o Mr. John J. Crisanti, Director
Office of Enforcement Policy
The Department of Labor and Industry
13 South Thirteenth Street
Richmond, Virginia 23219

RE: VR 425-02-03 Marine Terminals Standard for
Hazard Communication, 1917.28

Dear Mr. Saunders:

This will acknowledge receipt of the above-referenced regulations from the Department of Labor and Industry.

As required by § 9-6.14:4.1 C.4.(c) of the Code of Virginia, I have determined that these regulations are exempt from the operation of Article 2 of the Administrative Process Act, since they do not differ materially from those required by federal law.

Sincerely,

Joan W. Smith
Registrar of Regulations

JWS:jbc

* * * * *

Title of Regulation: VR 425-02-11. VOSH Administrative Regulations Manual (REPEALED).

Statutory Authority: §§ 40.1-6 and 40.1-22 of the Code of Virginia.

Effective Date: July 1, 1994.

Summary:

The Virginia Occupational Safety and Health (VOSH) Administrative Regulations Manual (ARM) was developed by the department to provide a framework of administrative rules and procedures for the operation of the VOSH program. This document was significantly impacted by legislative amendments to the Code of Virginia in 1992 and 1993 which altered the contest process by increasing the maximum penalty levels under the VOSH program and changed the original court of jurisdiction from the district court to the circuit court.

As a result of these comprehensive changes and their implications, the department developed for the Safety and Health Codes Board an emergency amendment to the ARM to incorporate the changes and eventually supersede the existing ARM. The emergency amendment was adopted by the board on June 21, 1993, with effective dates of June 30, 1993, until June 29, 1994.

The new Administrative Regulation (VR 425-02-95) was adopted by the board on April 25, 1994, and will supersede the emergency regulation on June 30, 1994. Therefore, this regulation is no longer necessary.

Summary of Public Comment and Agency Response: No public comment was received by the promulgating agency.

Agency Contact: Bonnie H. Robinson, Administrative Staff Specialist, Department of Labor and Industry, 13 South 13th Street, Richmond, VA 23219, telephone (804) 371-2631.

VA.R. Doc. No. R94-973; Filed May 11, 1994, 10:46 a.m.

* * * * *

REGISTRAR'S NOTICE: The following regulation filed by the Department of Labor and Industry is excluded from Article 2 of the Administrative Process Act in accordance with § 9-6.14:4.1 C 4(c) of the Code of Virginia, which excludes regulations that are necessary to meet the requirements of federal law or regulations, provided such regulations do not differ materially from those required by federal law or regulation. The Safety and Health Codes Board will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: VR 425-02-31. Construction Industry Standard for Hazard Communication (1926.59).

Statutory Authority: § 40.1-22(5) of the Code of Virginia.

Effective Date: July 1, 1994.

Summary:

The amendment to the existing Hazard Communication Standard includes a number of minor changes and technical corrections to further clarify the requirements and thereby help ensure full compliance and achieve protection for employees. In general, the change adds and clarifies certain exemptions from labeling and other requirements; modifies and clarifies aspects of the written hazard communication program and labeling requirements; clarifies and slightly modifies the duties of distributors, manufacturers and importers to provide material safety data sheet (MSDSs) to employees; and clarifies certain provisions regarding MSDSs.

Note on Incorporation By Reference

Pursuant to § 9-6.18 of the Code of Virginia, the Construction Industry Standard for Hazard Communication (1926.59) is declared a document generally available to the public and appropriate for incorporation by reference. For this reason the entire document will not be printed in The Virginia Register of Regulations. Copies of the document are available for inspection at the Department of Labor and Industry, 13 South 13th Street, Richmond, Virginia, and in the Office of the Registrar of Regulations, General Assembly Building, Capitol Square, Room 262, Richmond, Virginia.

On April 25, 1994, the Safety and Health Codes Board adopted an identical version of federal OSHA's amendment to the Construction Industry Standard for Hazard Communication, 29 CFR 1926.59, as published in the Federal Register, Vol. 59, No. 27, pp. 6169-6184, Wednesday, February 9, 1994. The amendments as adopted are not set out.

When the regulations, as set forth in the Construction Industry Standard for Hazard Communication, § 1926.59, are applied to the Commissioner of the Department of Labor and Industry or to Virginia employers, the following federal terms shall be considered to read as follows:

Federal Terms	VOSH Equivalent
29 CFR	VOSH Standard
Assistant Secretary	Commissioner of Labor and Industry
March 11, 1994	July 1, 1994

VA.R. Doc. No. R94-944; Filed May 2, 1994, 10:51 a.m.

Final Regulations



COMMONWEALTH of VIRGINIA

JOAN W. SMITH
REGISTRAR OF REGULATIONS

VIRGINIA CODE COMMISSION
General Assembly Building

510 CAPITOL STREET
RICHMOND, VIRGINIA 23219
(804) 786-3591

May 11, 1994

Mr. Linwood Saunders, Chairman
Virginia Safety and Health Codes Board
c/o Mr. John J. Crisanti, Director
Office of Enforcement Policy
The Department of Labor and Industry
13 South Thirteenth Street
Richmond, Virginia 23219

RE: VR 425-02-31 Amendment to Construction Industry Standard
for Hazard Communication, 1926.59

Dear Mr. Saunders:

This will acknowledge receipt of the above-referenced regulations
from the Department of Labor and Industry.

As required by § 9-6.14:4.1 C.4.(c). of the Code of Virginia, I
have determined that these regulations are exempt from the operation of
Article 2 of the Administrative Process Act, since they do not differ
materially from those required by federal law.

Sincerely,

Joan W. Smith
Registrar of Regulations

JWS:jbc



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Mr. Linwood Saunders, Chairman
Virginia Safety and Health Codes Board
c/o Mr. John J. Crisanti, Director
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The Department of Labor and Industry
13 South Thirteenth Street
Richmond, Virginia 23219

RE: VR 425-02-91 Construction Industry Standard for
Occupational Exposure to Cadmium, 1926.1127

Dear Mr. Saunders:

This will acknowledge receipt of the above-referenced regulations
from the Department of Labor and Industry.

As required by § 9-6.14:4.1 C.4.(c). of the Code of Virginia, I
have determined that these regulations are exempt from the operation of
Article 2 of the Administrative Process Act, since they do not differ
materially from those required by federal law.

Sincerely,

Joan W. Smith
Registrar of Regulations

JWS:jbc

Final Regulations

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REGISTRAR'S NOTICE: The following regulation filed by the Department of Labor and Industry is excluded from Article 2 of the Administrative Process Act in accordance with § 9-6.14:4.1 C 4(c) of the Code of Virginia, which excludes regulations that are necessary to meet the requirements of federal law or regulations, provided such regulations do not differ materially from those required by federal law or regulation. The Safety and Health Codes Board will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: VR 425-02-91. Construction Industry Standard for Occupational Exposure to Cadmium (~~1926.63~~) (1926.1127).

Statutory Authority: § 40.1-22(5) of the Code of Virginia.

Effective Date: July 1, 1994.

Summary:

The Safety and Health Codes Board adopted federal OSHA's redesignation of the Construction Standard for Occupational Exposure to Cadmium into a different subpart. The redesignation merges this construction standard with the newly created Subpart Z, Toxic and Hazardous Substances, which contains specific toxic substances standards for construction. The redesignation of the standard as published on September 14, 1992 (57 Fed. Reg. 42102), changes the construction number to 29 CFR 1926.1127 from 29 CFR 1926.63.

Note on Incorporation By Reference

Pursuant to § 9-6.18 of the Code of Virginia, the Construction Industry Standard for Occupational Exposure to Cadmium (1926.1127) is declared a document generally available to the public and appropriate for incorporation by reference. For this reason the entire document will not be printed in The Virginia Register of Regulations. Copies of the document are available for inspection at the Department of Labor and Industry, 13 South 13th Street, Richmond, Virginia, and in the Office of the Registrar of Regulations, General Assembly Building, Capitol Square, Room 262, Richmond, Virginia.

On April 25, 1994, the Safety and Health Codes Board adopted an identical version of the corrections to federal OSHA's final rule entitled, "Construction Industry Standard for Cadmium," 29 CFR 1926.1127, as published in the Federal Register, Vol. 59, No. 1, p. 215, Monday, January 3, 1994. The amendments as adopted are set out below.

When the regulations, as set forth in the Construction Industry Standard for Occupational Exposure to Cadmium, § 1926.63, are applied to the Commissioner of the Department of Labor and Industry or to Virginia employers, the following federal terms shall be considered to read as follows:

Federal Terms

Assistant Secretary
29 CFR 1926.63
29 CFR 1926.1127

VOSH Equivalent

Commissioner of Labor and Industry
1926.63
1926.1127

PART 1926 - (Amended)

Subpart Z - Toxic and Hazardous Substances

1. The authority citation for subpart Z of 29 CFR part 1926 continues to read as follows:

Authority: Sections 6 and 8. Occupational Safety and Health Act, 29 U.S.C. 655, 657, Secretary of Labor's Orders Nos. 12-71 (36 FR 8754), 8-76 (41 FR 25059), 9-83 (48 FR 35736) or 1-90 (55 FR 9033) as applicable and 29 CFR part 1911.

Section 1926.1102 not issued under 29 U.S.C. 655 or 29 CFR part 1911, also issued under 5 U.S.C. 653.

Section 1926.1103 through 1926.1118 also issued under 29 U.S.C. 653.

Section 1926.1128 also issued under 29 U.S.C. 653.

Section 1926.1145 and 1926.1147 also issued under 29 U.S.C. 653.

Section 1926.1148 also issued under 29 U.S.C. 653.

2. In part 1926, § 1926.63, *Cadmium*, is redesignated as § 1926.1127.

3. In paragraph (m)(4)(iii)(II) of (newly redesignated) § 1926.1127, the reference to "§ 1910.20(g)(1) and (2)" is changed to read "§ 1926.33(g)(1) and (2)"; in § 1926.1127(n)(1)(iii), (3)(iii), and (5)(i), the reference to "29 CFR 1910.20" is changed to read "§ 1926.33 of this part"; and in § 1926.1127(n)(6), the reference to "29 CFR 1910.20(h)" is changed to read "§ 1926.33(h) of this part."

*NOTE: A strike through appears in the above federal language because the board, at the request of VOSH, did not adopt the federal standard, Access to Employee Exposure and Medical Records, Construction Industry, 1926.33. Virginia has retained its unique general industry standard, 1910.20, and its applicability to construction. This Virginia standard, in reality, is what was the more comprehensive original 1980 federal OSHA standard for 29 CFR 1910.20

V.A.R. Doc. No. R94-045; Filed May 2, 1994, 10:51 a.m.

* * * * *

Title of Regulation: VR 425-02-95. Administrative Regulation for the Virginia Occupational Safety and Health Program.

Statutory Authority: § 40.1-22(5) of the Code of Virginia.

Effective Date: July 1, 1994.

Summary:

This final regulation is the first complete revision of the Administrative Regulation Manual adopted in 1986. It contains substantive changes primarily by defining additional terms, and in the clarification of the following issues: the 48-hour accident reporting requirements of employers, the agency's response to requests for information by subpoena, and the VOSH program's response to federal judicial action, such as vacation of § 1910.1000 permissible exposure limits (PEL).

This regulation is simplified by omitting requirements already stipulated in Title 40.1 of the Code of Virginia in those cases where no further regulatory language is necessary to carry out that mandate.

Summary of Public Comment and Agency Response: No public comment was received by the promulgating agency.

Agency Contact: Copies of the regulation may be obtained from Bonnie H. Robinson, Administrative Staff Specialist, Department of Labor and Industry, 13 South 13th Street, Richmond, VA 23219, telephone (804) 371-2631. There may be a charge for copies.

VR 425-02-95. Administrative Regulation for the Virginia Occupational Safety and Health Program.

PART I. DEFINITIONS.

§ 1.1. Definitions.

The following words and terms, when used in these regulations, shall have the following meaning, unless the context clearly indicates otherwise:

"Abatement period" means the period of time permitted for correction of a violation.

"Bureau of Labor Statistics" means the Bureau of Labor Statistics of the United States Department of Labor.

"Citation" means the notice to an employer that the commissioner has found a condition or conditions that violate Title 40.1 of the Code of Virginia or the standards, rules or regulations established by the commissioner or the board.

"Board" means the Safety and Health Codes Board.

"Commissioner" means the Commissioner of Labor and Industry. Except where the context clearly indicates the contrary, any reference to the commissioner shall include his authorized representatives.

"Commissioner of Labor and Industry" means only the Commissioner of Labor and Industry.

"Department" means the Virginia Department of Labor and Industry.

"De minimis violation" means a violation which has no direct or immediate relationship to safety and health.

"Employee" means an employee of an employer who is employed in a business of his employer.

"Employee representative" means a person specified by employees to serve as their representative.

"Employer" means any person or entity engaged in business who has employees but does not include the United States.

"Establishment" means, for the purpose of recordkeeping requirements, a single physical location where business is conducted or where services or industrial operations are performed, e.g., factory, mill, store, hotel, restaurant, movie theater, farm, ranch, bank, sales office, warehouse, or central administrative office. Where distinctly separate activities are performed at a single physical location, such as contract activities operated from the same physical location as a lumberyard; each activity is a separate establishment. In the public sector, an establishment is either (i) a single physical location where a specific governmental function is performed; or (ii) that location which is the lowest level where attendance or payroll records are kept for a group of employees who are in the same specific organizational unit, even though the activities are carried on at more than a single physical location.

"Failure to abate" means that the employer has failed to correct a cited violation within the period permitted for its correction.

"FOIA" means the [Virginia] Freedom of Information Act.

"Imminent danger condition" means any condition or practice in any place of employment such that a danger exists which could reasonably be expected to cause death or serious physical harm immediately or before the imminence of such danger can be eliminated through standard enforcement procedures provided by Title 40.1 of the Code of Virginia.

"OSHA" means the Occupational Safety and Health Administration of the United States Department of Labor.

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"Other violation" means a violation which is not, by itself, a serious violation within the meaning of the law but which has a direct or immediate relationship to occupational safety or health.

"Person" means one or more individuals, partnerships, associations, corporations, business trusts, legal representatives, or any organized group of persons.

"Public employer" means the Commonwealth, including its agencies, or any political subdivision or public body.

"Public employee" means any employee of a public employer. Volunteer members of volunteer fire departments, pursuant to § 27-42 of the Code of Virginia, members of volunteer rescue squads who serve without pay, and other volunteers pursuant to the Virginia State Government Volunteers Act are not public employees. Prisoners confined in jails controlled by any political subdivision of the Commonwealth and prisoners in institutions controlled by the Department of Corrections are not public employees unless employed by a public employer in a work-release program pursuant to § 53.1-60 or § 53.1-131 of the Code of Virginia.

"Recordable occupational injury and illness" means (i) a fatality, regardless of the time between the injury and death or the length of illness; (ii) a nonfatal case that results in lost work days; or (iii) a nonfatal case without lost work days which results in transfer to another job or termination of employment, which requires medical treatment other than first aid, or involves loss of consciousness or restriction of work or motion. This category also includes any diagnosed occupational illness which is reported to the employer but is not otherwise classified as a fatality or lost work day case.

"Repeated violation" means a violation deemed to exist in a place of employment that is substantially similar to a previous violation of a law, standard or regulation that was the subject of a prior final order against the same employer. A repeated violation results from an inadvertent or accidental act, since a violation otherwise repeated would be willful.

"Serious violation" means a violation deemed to exist in a place of employment if there is a substantial probability that death or serious physical harm could result from a condition which exists, or from one or more practices, means, methods, operations, or processes which have been adopted or are in use, in such place of employment, unless the employer did not, and could not with the exercise of reasonable diligence, know of the presence of the violation. The term "substantial probability" does not refer to the likelihood that illness or injury will result from the violative condition but to the likelihood that, if illness or injury does occur, death or serious physical harm will be the result.

"Standard" means an occupational safety and health standard which requires conditions, or the adoption or use

of one or more practices, means, methods, operations, or processes, reasonably necessary or appropriate to provide safe or healthful employment and places of employment.

"VOSH" means Virginia Occupational Safety and Health.

"Willful violation" means a violation deemed to exist in a place of employment where (i) the employer committed an intentional and knowing, as contrasted with inadvertent, violation and the employer was conscious that what he was doing constituted a violation; or (ii) the employer, even though not consciously committing a violation, was aware that a hazardous condition existed and made no reasonable effort to eliminate the condition.

"Working days" means Monday through Friday, excluding legal holidays, Saturday, and Sunday.

PART II. GENERAL PROVISIONS.

§ 2.1. Jurisdiction.

All Virginia statutes, standards, and regulations pertaining to occupational safety and health shall apply to every employer, employee and place of employment in the Commonwealth of Virginia except where:

1. The United States is the employer or exercises exclusive jurisdiction;
2. The federal Occupational Safety and Health Act of 1970 does not apply by virtue of § 4(b)(1) of that Act. The commissioner shall consider Federal OSHA case law in determining where jurisdiction over specific working conditions has been preempted by the regulations of a federal agency; or,
3. The employer is a public employer, as that term is defined in these regulations. In such cases, the Virginia laws, standards and regulations governing occupational safety and health are applicable as stated including §§ 1.1, 2.2, 6.3, 6.4, and 6.5 of these regulations.

§ 2.2. Applicability to public employers.

A. All occupational safety and health standards adopted by the board shall apply to public employers and their employees in the same manner as to private employers.

B. All sections of these regulations shall apply to public employers and their employees. Where specific procedures are set out for the public sector, such procedures shall take precedence.

C. The following portions of Title 40.1 of the Code of Virginia shall apply to public employers: §§ 40.1-49.4.A(1), 40.1-49.8, 40.1-51, 40.1-51.1, 40.1-51.2, 40.1-51.2:1, 40.1-51.3, 40.1-51.3:2, and 40.1-51.4:2.

D. Section 40.1-51.2:2 A of the Code of Virginia shall apply to public employers except that the commissioner shall not bring action in circuit court in the event that a voluntary agreement cannot be obtained.

E. Sections 40.1-49.4 F and 40.1-51.2:2 of the Code of Virginia shall apply to public employers other than the Commonwealth and its agencies.

F. If the commissioner determines that an imminent danger situation, as defined in § 40.1-49.4 F of the Code of Virginia, exists for an employee of the Commonwealth or one [~~or~~ of] its agencies, and if the employer does not abate that imminent danger immediately upon request, the Commissioner of Labor and Industry shall forthwith petition the Governor to direct that the imminent danger be abated.

G. If the commissioner is unable to obtain a voluntary agreement to resolve a violation of § 40.1-51.2:1 of the Code of Virginia by the Commonwealth or one of its agencies, the Commissioner of Labor and Industry shall petition for redress in the manner provided in these regulations.

§ 2.3. Notification and posting requirements.

Every employer shall post and keep posted any notice or notices, as required by the commissioner, including the Job Safety and Health Protection Poster which shall be available from the department. Such notices shall inform employees of their rights and obligations under the safety and health provisions of Title 40.1 of the Code of Virginia and these regulations. Violations of notification or posting requirements are subject to citation and penalty.

1. Such notice or notices, including all citations, petitions for variances or extensions of abatement periods, orders, and other documents of which employees are required to be informed by the employer under statute or by these regulations, shall be delivered by the employer to any authorized employee representative, and shall be posted at a conspicuous place where notices to employees are routinely posted and shall be kept in good repair and in unobstructed view. The document must remain posted for 10 working days unless a different period is prescribed elsewhere in Title 40.1 of the Code of Virginia or these regulations.

2. A citation issued to an employer, or a copy thereof, shall remain posted in a conspicuous place and in unobstructed view at or near each place of alleged violation for three working days or until the violation has been abated, whichever is longer.

3. A copy of any written notice of contest shall remain posted until all proceedings concerning the contest have been completed.

4. Upon receipt of a subpoena, the employer shall use

the methods set forth in subsection B of this section to further notify his employees and any authorized employee representative of their rights to party status. This written notification shall include both the date, time and place set for court hearing, and any subsequent changes to hearing arrangements. The notification shall remain posted until commencement of the hearing or until an earlier disposition.

§ 2.4. Accident reports.

A. All employers, regardless of the number of their employees, shall report to the commissioner within 48 hours any [~~accident~~ work-related incident] which results in the death of any employee or the [inpatient] hospitalization of five or more employees.

B. If an employer does not learn of a reportable [~~accident~~ incident] at the time it occurs, and the [~~accident~~ incident] would otherwise be reportable under this section, the employer shall report to the department within 48 hours of [~~learning of such an accident~~ the time the incident is reported to any agent or employee of the employer] . Whether or not an [~~accident~~ incident] is immediately reportable, if an employee dies of the effects of [~~an employment accident~~ a reportable incident] within 30 days of that [~~accident~~ incident], the employer shall report to the department within 48 hours after learning of such death. Reports required by this section shall be submitted by telephone or in person to the department.

C. Each report required by this section shall relate the [~~circumstances of the accident~~ following information: establishment name, location of incident, time of the incident,] the number of fatalities or [~~hospitalizations and hospitalized employees,~~] the extent of any injuries [, a brief description of the incident, contact person and phone number] . The commissioner may require additional reports in writing or otherwise, as deemed necessary, concerning the incident.

§ 2.5. Occupational injury and illness records.

A. Every employer subject to the safety and health provisions of Title 40.1 of the Code of Virginia, except those employers exempted under the current OSHA Recordkeeping Program, shall maintain an occupational injury and illness log and summary in each individual establishment and may use for this purpose Occupational Safety and Health Administration Form, OSHA No. 200, or a substitute that is as detailed, easily readable, and understandable as the OSHA No. 200.

B. Each recordable injury and illness shall be entered on the log and summary as early as is practicable but no later than six working days after receiving information that a recordable injury or illness has occurred.

C. Employers may maintain the log and summary at a place other than the establishment or by means of data processing equipment if:

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1. There is available at the place that the log and summary is maintained sufficient information to bring the log and summary to date within six working days after receiving information that a recordable case has occurred, and

2. At each employer's establishment(s), there is available a copy of the log and summary reflecting complete and current (within 45 calendar days) the injury and illness experience of that establishment.

D. The log shall be established on a calendar year basis.

E. Every employer required to maintain a log shall also maintain a supplementary record of occupational injuries and illnesses and may use for this purpose Occupational Safety and Health Administration Form, OSHA No. 101. Employer's First Report of Accident, VWC Form No. 3 (Virginia Workers' Compensation Commission), is acceptable as a substitute for OSHA No. 101. Other forms will be acceptable if they contain the information required by OSHA Form No. 101.

F. Every employer who is required by the provisions of subsection A to maintain a log shall also compile an annual summary of occupational injuries and illnesses based on the information contained in the log. The summary for the previous calendar year must be posted in accordance with § 2.3 of these regulations by February 1 and remain posted until March 1. Occupational Safety and Health Form No. 200 shall be used for this purpose.

1. The employer or the employee who prepares the log and summary shall certify that the summary is accurate and complete. This certification shall be indicated by the signature at the bottom of the summary or by attaching a separate verifying statement to the summary.

2. For employees who do not report to any fixed establishment on a regular basis, the annual summary shall be presented or mailed during the month of February to each employee who receives a paycheck during that month.

3. It is not necessary for multi-establishment employers to post summaries for those operations which have been closed down.

G. All safety and health records at each establishment shall be available for inspection and copying by the commissioner, officials from the Occupational Safety and Health Administration or the Bureau of Labor Statistics of the U.S. Department of Labor, and representatives of the U.S. Department of Health and Human Services conducting investigations under the Occupational Safety and Health Act.

H. The log and summary of all recordable occupational injuries and illnesses (OSHA No. 200) provided for in this section shall, upon request, be made available by the

employer to any employee, former employee, and to his representatives for examination and copying in a reasonable manner and at reasonable times. The employee, former employee, and his representatives shall have access to the log for any establishment in which the employee is or has been employed.

I. Every employer shall prepare and maintain any other records determined by the commissioner to be necessary and submit, upon request of the commissioner, records pertaining to occupational safety and health.

J. All records required to be maintained in accordance with this section shall be retained in each establishment for five years after the year to which they pertain.

K. Where an employer has conveyed his ownership interests, both the new and the prior employers are responsible for maintaining records only for that period of the year during which he had any ownership interests. The new owner shall preserve those records, if any, of the previous owner required to be kept under this section. These records shall be retained for the remainder of the five year period required under subsection J of this section.

L. Employers of employees engaged in physically dispersed operations such as occur in construction, installation, repair, or service activities who do not report to any fixed establishment on a regular basis but are subject to common supervision may satisfy the provisions of this section with respect to such employees by:

1. Maintaining the required records for each operation or group of operations which is subject to common supervision, e.g., field superintendent, field supervisor, etc., in an established central place;

2. Having the address and telephone number of the central place to provide information from such records during normal business hours in response to requests by telephone or by mail from the authorized parties listed in this section, and

3. Having personnel available during normal business hours at the central place to provide by telephone or by mail requested information from such records maintained there.

§ 2.6. Annual survey.

As required by the U. S. Department of Labor and the Bureau of Labor Statistics, any employer shall complete an annual survey data form as required by the commissioner. This form shall be submitted to the commissioner and used for the compilation of statistical and other information.

§ 2.7. Access to employee medical and exposure records.

A. An employee and his authorized representative shall

have access to his exposure and medical records required to be maintained by the employer.

B. When required by a standard, a health care professional under contract to the employer or employed by the employer shall have access to the exposure and medical records of an employee only to the extent necessary to comply with the requirements of the standard and shall not disclose or report without the employee's express written consent to any person within or outside the workplace except as required by the standard.

C. Under certain circumstances it may be necessary for the commissioner to obtain access to employee exposure and medical records to carry out statutory and regulatory functions. However, due to the substantial personal privacy interests involved, the commissioner shall seek to gain access to such records only after a careful determination of the need for such information and only with appropriate safeguards described at 29 CFR 1913.10(i) in order to protect individual privacy. In the event that the employer requests the commissioner to wait 24 hours for the presence of medical personnel to review the records, the commissioner will do so on presentation of an affidavit that the employer has not and will not modify or change any of the records. The commissioner's examination and use of this information shall not exceed that which is necessary to accomplish the purpose for access. Personally identifiable medical information shall be retained only for so long as is needed to carry out the function for which it was sought. Personally identifiable information shall be kept secure while it is being used and shall not be released to other agencies or to the public except under certain narrowly defined circumstances outlined at 29 CFR 1913.10(m).

D. In order to implement the policies described in subsection C of this section, the rules and procedures of 29 CFR Part 1913.10, Rules of Agency Practice and Procedure Concerning Access to Employee and Medical Records, are hereby expressly incorporated by reference. When these rules and procedures are applied to the commissioner the following federal terms should be considered to read as below:

FEDERAL TERM	VOSH EQUIVALENT
Agency	Virginia Department of Labor and Industry
OSHA	VOSH
Assistant Secretary	Commissioner
Office of the Solicitor of Labor	Office of the Attorney General
Department of Justice	Office of the Attorney General
Privacy Act	Va. Code § 2.1-377 to -386

§ 2.8. Release of information and disclosure pursuant to

requests under the Virginia Freedom of Information Act and subpoenas.

A. Pursuant to the Virginia Freedom of Information Act (FOIA) and with the exceptions stated in subsections B through [E H] of this section, employers, employees and their representatives shall have access to information gathered in the course of an inspection.

B. Interview statements of employers, owners, operators, agents, or employees given to the commissioner in confidence pursuant to § 40.1-49.8 of the Code of Virginia shall not be disclosed for any purpose, except to the individual giving the statement.

[C. The commissioner, in response to a subpoena, order, or other demand of a court or other authority in connection with a proceeding to which the department is not a party, shall not disclose any information or produce any material acquired as part of the performance of his official duties or because of his official status without the approval of the Commissioner of Labor and Industry.

D. The commissioner shall disclose information and statistics gathered pursuant to the enforcement of Virginia's occupational safety and health laws, standards, and regulations where it has been determined that such a disclosure will serve to promote the safety, health, and welfare of employees. Any person requesting disclosure of such information and statistics should include in his written request any information that will aid the commissioner in this determination.]

[E. C.] All file documents contained in case files which are under investigation, and where a citation has not been issued, are not disclosable until:

1. The decision has been made not to issue citations; or
2. Six months has lapsed following the occurrence of an alleged violation.

[F. D.] Issued citations, orders of abatement and proposed penalties are public documents and are releasable upon a written request. All other file documents in cases where a citation has been issued are not disclosable until the case is a final order of the commissioner or the court.

[G. E.] Information required to be kept confidential by law shall not be disclosed by the commissioner or by any employee of the department. In particular, the following specific information is deemed to be nondisclosable:

1. The identity of and statements of an employee or employee representative who has complained of hazardous conditions to the commissioner;
2. The identities of employers, owners, operators, agents or employees interviewed during inspections

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and their interview statements;

3. Employee medical and personnel records obtained during VOSH inspections. Such records may be released to the employee or his duly authorized representative upon a written, and endorsed request; and

4. Employer trade secrets, commercial, and financial data.

[H. F.] The commissioner may decline to disclose a document that is excluded from the disclosure requirements of the Virginia FOIA, particularly documents and evidence related to criminal investigations, writings protected by the attorney-client privilege, documents compiled for use in litigation and personnel records.

[F. G.] An effective program of investigation and conciliation of complaints of discrimination requires confidentiality. Accordingly, disclosure of records of such complaints, investigations, and conciliations will be presumed to not serve the purposes of Title 40.1 of the Code of Virginia, except for statistical and other general information that does not reveal the identities of particular employers or employees.

[F. H.] All information gathered through participation in Consultation Services or Training Programs of the department shall be withheld from disclosure except for statistical data which does not identify individual employers.

[I.] The commissioner, in response to a subpoena, order, or other demand of a court or other authority in connection with a proceeding to which the department is not a party, shall not disclose any information or produce any material acquired as part of the performance of his official duties or because of his official status without the approval of the Commissioner of Labor and Industry.

J. The commissioner shall disclose information and statistics gathered pursuant to the enforcement of Virginia's occupational safety and health laws, standards, and regulations where it has been determined that such a disclosure will serve to promote the safety, health, and welfare of employees. Any person requesting disclosure of such information and statistics should include in his written request any information that will aid the commissioner in this determination.]

§ 2.9. Complaints.

A. Any person who believes that a safety or health hazard exists in a workplace may request an inspection by giving notice to the commissioner. Written complaints signed by an employee or an authorized representative will be treated as formal complaints. Complaints by persons other than employees and authorized representatives and unsigned complaints by employees or authorized representatives shall be treated as nonformal

complaints. Nonformal complaints will generally be handled by letter and formal complaints will generally result in an inspection.

B. For purposes of this section and § 40.1-51.2(b) of the Code of Virginia, the representative(s) that will be recognized as authorized by employees for such action shall be:

1. A representative of the employee bargaining unit;
2. Any member of the employee's immediate family acting on behalf of the employee; or
3. A lawyer or physician retained by the employee.

C. A written complaint may be preceded by an oral complaint at which time the commissioner will either give instructions for filing the written complaint or provide forms for that purpose. Section 40.1-51.2(b) of the Code of Virginia stipulates that the written complaint follow an oral complaint by no more than two working days. However, if an oral complaint gives the commissioner reasonable grounds to believe that a serious condition or imminent danger situation exists, the commissioner may cause an inspection to be conducted as soon as possible without waiting for a written complaint.

D. A complaint should allege that a violation of safety and health laws, standards, rules, or regulations has taken place. The violation or hazard should be described with reasonable particularity.

E. A complaint will be classified as formal or nonformal and be evaluated to determine whether there are reasonable grounds to believe that the violation or hazard complained of exists.

1. If the commissioner determines that there are no reasonable grounds for believing that the violation or hazard exists, the employer and the complainant shall be informed in writing of the reasons for this determination.
2. An employee or authorized representative may obtain review of the commissioner's determination that no reasonable grounds for believing that the violation or hazard exists by submitting a written statement of his position with regard to the issue. Upon receipt of such written statement a further review of the matter will be made which may include a requested written statement of position from the employer, further discussions with the complainant or an informal conference with complainant or employer if requested by either party. After review of the matter, the commissioner shall affirm, modify or reverse the original determination and furnish the complainant and the employer written notification of his decision.

F. If the commissioner determines that the complaint is

formal and offers reasonable grounds to believe that a hazard or violation exists, then an inspection will be conducted as soon as possible. Valid nonformal complaints may be resolved by letter or may result in an inspection if the commissioner determines that such complaint establishes probable cause to conduct an inspection.

G. If there are several complaints to be investigated, the commissioner may prioritize them by considering such factors as the gravity of the danger alleged and the number of exposed employees.

H. At the beginning of the inspection the employer shall be provided with a copy of the written complaint. The complainant's name shall be deleted and any other information which would identify the complainant shall be reworded or deleted so as to protect the complainant's identity.

I. An inspection pursuant to a complaint may cover the entire operation of the employer, particularly if it appears to the commissioner that a full inspection is warranted. However, if there has been a recent inspection of the worksite or if there is reason to believe that the alleged violation or hazard concerns only a limited area or aspect of the employer's operation, the inspection may be limited accordingly.

J. After an inspection based on a complaint, the commissioner shall inform the complainant in writing whether a citation has been issued and briefly set forth the reasons if not. The commissioner shall provide the complainant with a copy of any resulting citation issued to the employer.

§ 2.10. Discrimination; discharge or retaliation; remedy for retaliation.

A. In carrying out his duties under § 40.1-51.2:2 of the Code of Virginia, the commissioner shall consider case law, regulations, and formal policies of federal OSHA. An employee's engagement in activities protected by Title 40.1 does not automatically render him immune from discharge or discipline for legitimate reasons. Termination or other disciplinary action may be taken for a combination of reasons, involving both discriminatory and nondiscriminatory motivations. In such a case, a violation of § 40.1-51.2:1 of the Code of Virginia has occurred if the protected activity was a substantial reason for the action, or if the discharge or other adverse action would not have taken place "but for" engagement in protected activity.

Employee activities protected by § 40.1-51.2:1 of the Code of Virginia include, but are not limited to:

1. Making any complaint to his employer or any other person under or related to the safety and health provisions of Title 40.1 of the Code of Virginia;
2. Instituting or causing to be instituted any

proceeding under or related to the safety and health provisions of Title 40.1 of the Code of Virginia;

3. Testifying or intending to testify in any proceeding under or related to the safety and health provisions of Title 40.1 of the Code of Virginia;

4. Cooperating with or providing information to the commissioner during a worksite inspection; or

5. Exercising on his own behalf or on behalf of any other employee any right afforded by the safety and health provisions of Title 40.1 of the Code of Virginia.

Discharge or discipline of an employee who has refused to complete an assigned task because of a reasonable fear of injury or death will be considered retaliatory only if the employee has sought abatement of the hazard from the employer and the statutory procedures for securing abatement would not have provided timely protection. The condition causing the employee's apprehension of death or injury must be of such a nature that a reasonable person, under the circumstances then confronting the employee, would conclude that there is a real danger of death or serious injury and that there is insufficient time, due to the urgency of the situation, to eliminate the danger through resort to regular statutory enforcement. In addition, in such circumstances, the employee, where possible, must also have sought from his employer, and been unable to obtain, an abatement of the dangerous condition.

Disciplinary measures taken by employers solely in response to employee refusal to comply with appropriate safety rules and regulations shall not be regarded as retaliatory action prohibited by § 40.1-51.2:1 of the Code of Virginia.

B. A complaint pursuant to § 40.1-51.2:2 of the Code of Virginia may be filed by the employee himself or anyone authorized to act in his behalf.

The investigation of the commissioner shall include an opportunity for the employer to furnish the commissioner with any information relevant to the complaint.

An attempt by an employee to withdraw a previously filed complaint shall not automatically terminate the investigation of the commissioner. Although a voluntary and uncoerced request from the employee that his complaint be withdrawn shall receive due consideration, it shall be the decision of the commissioner whether further action is necessary to enforce the statute.

The filing of a retaliation complaint with the commissioner shall not preclude the pursuit of a remedy through other channels. Where appropriate, the commissioner may postpone his investigation or defer to the outcome of other proceedings.

PART III.

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OCCUPATIONAL SAFETY AND HEALTH STANDARDS.

§ 3.1. General industry standards.

The occupational safety or health standards adopted as rules or regulations by the board either directly or by reference, from 29 CFR Part 1910 shall apply by their own terms to all employers and employees at places of employment covered by the Virginia State Plan for Occupational Safety and Health.

§ 3.2. Construction industry standards.

The occupational safety or health standards adopted as rules or regulations by the Virginia Safety and Health Codes Board either directly, or by reference, from 29 C.F.R. Part 1926 shall apply by their own terms to all employers and employees engaged in either construction work or construction related activities covered by the Virginia State Plan for Occupational Safety and Health.

1. For the purposes of the applicability of such Part 1926 standards, the key criteria utilized to make such a decision shall be the activities taking place at the worksite, not the primary business of the employer. Construction work shall generally include any building, altering, repairing, improving, demolishing, painting or decorating any structure, building, highway, or roadway; and any draining, dredging, excavation, grading or similar work upon real property. Construction also generally includes work performed in traditional construction trades such as carpentry, roofing, masonry work, plumbing, trenching and excavating, tunnelling, and electrical work. Construction does not include maintenance, alteration or repair of mechanical devices, machinery, or equipment, even when the mechanical device, machinery or equipment is part of a pre-existing structure.

2. Certain standards of 29 C.F.R. Part 1910 have been determined by federal OSHA to be applicable to construction and have been adopted for this application by the board.

3. The standards adopted from 29 C.F.R. Part 1910.19 and 29 C.F.R. Part 1910.20 containing respectively, special provisions regarding air contaminants and requirements concerning access to employee exposure and medical records shall apply to construction work as well as general industry.

§ 3.3. Agriculture standards.

The occupational safety or health standards adopted as rules or regulations by the board either directly, or by reference, from 29 CFR Part 1928 shall apply by their own terms to all employers and employees engaged in either agriculture or agriculture related activities covered by the Virginia State Plan for Occupational Safety and

Health.

§ 3.4. Maritime standards.

The occupational safety or health standards adopted as rules or regulations by the board either directly, or by reference, from 29 C.F.R. Part 1915 and 29 C.F.R. Part 1917 shall apply by their own terms to all public sector employers and employees engaged in maritime related activities covered by the Virginia State Plan for Occupational Safety and Health.

§ 3.5. General duty.

Where a recognized hazard exists that is causing or likely to cause death or serious physical harm, and specific general industry, construction and agricultural standards do not apply or may not exist, the requirements of § 40.1-51.1(a) of the Code of Virginia shall apply to all employers covered by the Virginia State Plan for Occupational Safety and Health.

§ 3.6. Public participation in the adoption of standards.

Interested parties, e.g., employers, employees, employee representatives, and the general public, may offer written and oral comments in accordance with the requirements of the Public Participation Guidelines of either the board or the department, as appropriate, regarding the adoption, alteration, amendment, or repeal of any rules or regulations by the board or the commissioner to further protect and promote the safety and health of employees in places of employment over which the board or the commissioner have jurisdiction.

§ 3.7. Response to judicial action.

A. Any federal occupational safety or health standard, or portion thereof, adopted as rule or regulation by the board either directly, or by reference, and subsequently stayed by an order of any federal court will not be enforced by the commissioner until the stay has been lifted. Any federal standard which has been administratively stayed by OSHA will continue to be enforced by the commissioner until the stay has been reviewed by the board. The board will consider adoption or rejection of any federal administrative stay and will also subsequently review and then consider adoption or rejection of the lifting of such stays by federal OSHA.

B. The continued enforcement of any VOSH standard, or portion thereof, which is substantively identical to a federal standard that has been vacated by an order of any federal court [,] shall be at the discretion of the commissioner until such time as the standard and related federal judicial action have been reviewed by the board. The board shall consider the revocation or the repromulgation of any such standard.

PART IV. VARIANCES.

§ 4.1. General provisions.

A. Any employer or group of employers desiring a permanent or temporary variance from a standard or regulation pertaining to occupational safety and health may file with the commissioner a written application which shall be subject to the following policies:

1. A request for a variance shall not preclude or stay a citation or bill of complaint for violation of a safety or health standard;

2. No variances on recordkeeping requirements required by the U.S. Department of Labor shall be granted by the commissioner;

3. An employer, or group of employers, who has applied for a variance from the U.S. Department of Labor, and whose application has been denied on its merits, shall not be granted a variance by the commissioner unless there is a showing of changed circumstances significantly affecting the basis upon which the variance was originally denied;

4. An employer to whom the U.S. Secretary of Labor has granted a variance under OSHA provisions shall document this variance to the commissioner. In such cases, unless compelling local circumstances dictate otherwise, the variance shall be honored by the commissioner without the necessity of following the formal requirements which would otherwise be applicable. In addition, the commissioner will not withdraw a citation for violation of a standard for which the Secretary of Labor has granted a variance unless the commissioner previously received notice of and decided to honor the variance; and

5. Incomplete applications will be returned within 30 days to the applicant with a statement indicating the reason or reasons that the application was found to be incomplete.

B. In addition to the information specified in §§ 4.2 A and 4.3 A of this regulation, every variance application shall contain the following:

1. A statement that the applicant has informed affected employees of the application by delivering a copy of the application to their authorized representative, if there is one, as well as having posted, in accordance with § 2.3 of these regulations, a summary of the application which indicates where a full copy of the application may be examined.

2. A statement indicating that the applicant has posted, with the summary of the application described above, the following notice: "Affected employees or their representatives have the right to petition the Commissioner of Labor and Industry for an opportunity to present their views, data, or arguments on the requested variance, or they may submit their

comments to the commissioner in writing. Petitions for a hearing or written comments should be addressed to the Commissioner of Labor and Industry, Powers-Taylor Building, 13 South Thirteenth Street, Richmond, VA 23219. Such petitions will be accepted if they are received within 30 days from the posting of this notice or within 30 days from the date of publication of the commissioner's notice that public comments concerning this matter will be accepted, whichever is later."

3. A statement indicating whether an application for a variance from the same standard or rule has been made to any federal agency or to an agency of another state. If such an application has been made, the name and address of each agency contacted shall be included.

C. Upon receipt of a complete application for a variance, the commissioner shall publish a notice of the request in a newspaper of statewide circulation within 30 days after receipt, advising that public comments will be accepted for 30 days and that an informal hearing may be requested in conformance with subsection D of this section. Further, the commissioner may initiate an inspection of the establishment in regard to the variance request.

D. If within 30 days of the publication of notice the commissioner receives a request to be heard on the variance from the employer, affected employees, the employee representative, or other employer(s) affected by the same standard or regulation, the commissioner will schedule a hearing with the party or parties wishing to be heard and the employer requesting the variance. The commissioner may also schedule a hearing upon his own motion. The hearing will be held within a reasonable time and will be conducted informally in accordance with § 9-6.14:11 of the Code of Virginia unless the commissioner finds that there is a substantial reason to proceed under the formal provisions of § 9-6.14:12 of the Code of Virginia.

E. If the commissioner has not been petitioned for a hearing on the variance application, a decision on the application may be made promptly after the close of the period for public comments. This decision will be based upon the information contained in the application, the report of any variance inspection made concerning the application, any other pertinent staff reports, federal OSHA comments or public records, and any written data and views submitted by employees, employee representatives, other employers, or the public.

F. The commissioner will grant a variance request only if it is found that the employer has met by a preponderance of the evidence, the requirements of either § 4.2 B 4, or § 4.3 B 4, of these regulations.

1. The commissioner shall advise the employer in writing of the decision and shall send a copy to the

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employee representative if applicable. If the variance is granted, a notice of the decision will be published in a newspaper of statewide circulation.

2. The employer shall post a copy of the commissioner's decision in accordance with § 2.3 of these regulations.

G. Any party may within 15 days of the commissioner's decision file a notice of appeal to the board. Such appeal shall be in writing, addressed to the board, and include a statement of how other affected parties have been notified of the appeal. Upon notice of a proper appeal, the commissioner shall advise the board of the appeal and arrange a date for the board to consider the appeal. The commissioner shall advise the employer and employee representative of the time and place that the board will consider the appeal. Any party that submitted written or oral views or participated in the hearing concerning the original application for the variance shall be invited to attend the appeal hearing. If there is no employee representative, a copy of the commissioner's letter to the employer shall be posted by the employer in accordance with the requirements of § 2.3 of these regulations.

H. The board shall sustain, reverse, or modify the commissioner's decision based upon consideration of the evidence in the record upon which the commissioner's decision was made and the views and arguments presented as provided above. The burden shall be on the party filing the appeal to designate and demonstrate any error by the commissioner which would justify reversal or modification of the decision. The issues to be considered by the board shall be those issues that could be considered by a court reviewing agency action in accordance with § 9-6.14:17 of the Code of Virginia. All parties involved shall be advised of the board's decision within 10 working days after the hearing of the appeal.

§ 4.2. Temporary variances.

A. The commissioner shall give consideration to an application for a temporary variance from a standard or regulation only if the employer or group of employers is unable to comply with that standard or regulation by its effective date for good cause and files an application which meets the requirements set forth in this section. No temporary variance shall be granted for longer than the time needed to come into compliance with the standard or one year, whichever is shorter.

B. A letter of application for a temporary variance shall be in writing and contain the following information:

1. Name and address of the applicant;
2. Address of the place or places of employment involved;
3. Identification of the standard or part thereof from which a temporary variance is sought; and

4. Evidence to establish that:

a. The applicant is unable to comply with a standard by its effective date because professional or technical personnel or materials and equipment needed to come into compliance with the standard are unavailable, or because necessary construction or alteration of facilities cannot be completed by the effective date;

b. The applicant is taking effective steps to safeguard his employees against the hazards covered by the standard; and

c. The applicant has an effective program for coming into compliance with the standard as quickly as practicable.

C. A temporary variance may be renewed if the application for renewal is filed at least 90 days prior to the expiration date and if the requirements of subsection A of this section are met. A temporary variance may not be renewed more than twice.

§ 4.3. Permanent variances.

A. Applications filed with the commissioner for a permanent variance from a standard or regulation shall be subject to the requirements of § 4.1 of these regulations and the following additional requirements.

B. A letter of application for a permanent variance shall be submitted in writing by an employer or group of employers and shall contain the following information:

1. Name and address of the applicant;
2. Address of the place or places of employment involved;
3. Identification of the standard, or part thereof for which a permanent variance is sought; and
4. A description of the conditions, practices, means, methods, operations, or processes used and evidence that these would provide employment and a place of employment as safe and healthful as would be provided by the standard from which a variance is sought.

C. A permanent variance may be modified or revoked upon application by an employer, employees, or by the commissioner in the manner prescribed for its issuance at any time except that the burden shall be upon the party seeking the change to show altered circumstances justifying a modification or revocation.

§ 4.4. Interim order.

A. Application for an interim order granting the variance until final action by the commissioner may be

made by the employer prior to, or concurrent with, the submission of an application for a variance.

B. A letter of application for an interim order shall include statements as to why the interim order should be granted and shall include a statement that it has been posted in accordance with § 2.3 of these regulations. The provisions contained in §§ 4.1 A, 4.1 B 1 and 4.1 B 3 of these regulations shall apply to applications for interim orders in the same manner as they do to variances.

C. The commissioner shall grant the interim order if the employer has shown by clear and convincing evidence that effective methods to safeguard the safety and health of employees have been implemented. No interim order shall have effect for more than 180 days. If an application for an interim order is granted, the employer shall be so notified and it shall be a condition of the order that employees shall be advised of the order in the same manner as used to inform them of the application for a variance.

D. If the application for an interim order is denied, the employer shall be so notified with a brief statement of the reason for denial.

PART V. INSPECTIONS.

§ 5.1. Advance notice.

A. Where advance notice of an inspection has been given to an employer, the employer, upon request of the commissioner, shall promptly notify the authorized employee representative of the inspection if the employees have such a representative.

B. An advance notice of a safety or health inspection may be given by the commissioner only in the following circumstances:

1. In cases of imminent danger;
2. Where it is necessary to conduct inspections at times other than regular working hours;
3. Where advance notice is necessary to assure the presence of personnel needed to conduct the inspection; or
4. Where the commissioner determines that advance notice will insure a more effective and thorough inspection.

§ 5.2. Walkthrough.

Walkthrough by the commissioner for the inspection of any workplace includes the following privileges.

1. The commissioner shall be in charge of the inspection and, as part of an inspection, may question

privately any employer, owner, operator, agent, or employee. The commissioner shall conduct the interviews of persons during the inspection or at other convenient times.

2. As part of an inspection, the commissioner may take or obtain photographs, video recordings, audio recordings and samples of materials, and employ other reasonable investigative techniques as deemed appropriate. As used herein, the term "employ other reasonable investigative techniques" includes, but is not limited to, the use of devices to measure employee exposures and the attachment of personal sampling equipment such as dosimeters, pumps, badges and other devices to employees in order to monitor their exposures.

3. Any employee representative selected to accompany the commissioner during the inspection of the workplace shall be an employee of the employer. Additional employer representatives and employee representatives may be permitted by the commissioner to accompany the inspection team where the commissioner determines such additional persons will aid in the inspection. A different employer representative or employee representative may accompany the commissioner during each phase of the inspection if, in the determination of the commissioner, this will aid in the conduct of the inspection.

4. The commissioner may limit the number of representatives when the inspection group would be of such size as to interfere with the inspection or create possible safety hazards, or when the representative does not represent an employer or employee present in the particular area under inspection.

5. In such cases as stated in subdivision 4 of this section, the commissioner must give each walkthrough representative the opportunity to advise of possible safety or health hazards and then proceed with the inspection without walkthrough representatives. Whenever the commissioner has limited the number of employee walkthrough representatives, a reasonable number of employees shall be consulted during the inspection concerning possible safety or health hazards.

6. Technical personnel such as safety engineers and industrial hygienists or other consultants to the commissioner or the employer may accompany the commissioner if the commissioner determines that their presence would aid in the conduct of the inspection and agreement is obtained from the employer or the commissioner obtains an order under § 40.1-6(8)(b) of the Code of Virginia. All such consultants shall be bound by the confidentiality requirements of § 40.1-51.4:1 of the Code of Virginia.

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7. The commissioner is authorized to dismiss from the inspection party at any time any person or persons whose conduct interferes with the inspection.

§ 5.3. Trade secrets.

The following rules shall govern the treatment of trade secrets.

1. At the beginning of an inspection the commissioner shall request that the employer identify any areas of the worksite that may contain or reveal a trade secret. At the close of an inspection the employer shall be given an opportunity to review the information gathered from those areas and identify to the commissioner that information which contains or may reveal a trade secret.

2. The employer shall notify the commissioner prior to the case becoming a final order of any information obtained during the inspection which is to be identified as containing trade secrets.

3. Properly identified trade secrets shall be kept in a separate case file in a secure area not open for inspection to the general public. The separate case file containing trade secrets shall be protected from disclosure in accordance with § 40.1-51.4:1 of the Code of Virginia.

4. Upon the request of an employer, any employee serving as the walkthrough representative in an area containing trade secrets shall be an employee in that area or an employee authorized by the employer to enter that area. Where there is no such employee representative, the commissioner will interview a reasonable number of employees working in that area concerning matters of safety and health.

PART VI. CITATION AND PENALTY.

§ 6.1. Issuance of citation and proposed penalty.

A. Each citation shall be in writing and describe with particularity the nature of the violation or violations, including a reference to the appropriate safety or health provision of Title 40.1 of the Code of Virginia or the appropriate rule, regulation, or standard. In addition, the citation must fix a reasonable time for abatement of the violation. The citation will contain substantially the following: "NOTICE: This citation will become a final order of the commissioner unless contested within fifteen working days from the date of receipt by the employer". The citation may be delivered to the employer or his agent by the commissioner or may be sent by certified mail or by personal service to an officer or agent of the employer or to the registered agent if the employer is a corporation.

B. A citation issued under subsection A to an employer

who violates any VOSH law, standard, rule or regulation shall be vacated if such employer demonstrates that:

1. Employees of such employer have been provided with the proper training and equipment to prevent such a violation;

2. Work rules designed to prevent such a violation have been established and adequately communicated to employees by such employer and have been effectively enforced when such a violation has been discovered;

3. The failure of employees to observe work rules led to the violation; and

4. Reasonable steps have been taken by such employer to discover any such violation.

C. For the purposes of subsection B only, the term "employee" shall not include any officer, management official or supervisor having direction, management control or custody of any place of employment which was the subject of the violative condition cited.

D. The penalties as set forth in § 40.1-49.4 of the Code of Virginia shall also apply to violations relating to the requirements for recordkeeping, reports or other documents filed or required to be maintained and to posting requirements.

E. In determining the amount of the proposed penalty for a violation the commissioner will ordinarily be guided by the system of penalty adjustment set forth in the VOSH Field Operations Manual. In any event the commissioner shall consider the gravity of the violation, the size of the business, the good faith of the employer, and the employer's history of previous violations.

§ 6.2. Contest of citation or proposed penalty; general proceedings.

A. An employer to whom a citation or proposed penalty has been issued may contest the citation by notifying the commissioner in writing of the contest. The notice of contest must be mailed or delivered by hand within 15 working days from the receipt of the citation or proposed penalty. No mistake, inadvertence, or neglect on the part of the employer shall serve to extend the 15 working day period in which the employer must contest.

B. The notice of contest shall indicate whether the employer is contesting the alleged violation, the proposed penalty or the abatement time.

C. The employer's contest of a citation or proposed penalty shall not affect the citation posting requirements of § 2.3 of these regulations unless and until the court ruling on the contest vacates the citation.

D. When the commissioner has received written

notification of a contest of citation or proposed penalty, he will attempt to resolve the matter by settlement, using the procedures of §§ 8.1 and 8.2 of these regulations.

E. If the matter is not settled or it is determined that settlement does not appear probable, the commissioner will initiate judicial proceedings by referring the contested issues to the appropriate Commonwealth's Attorney and arranging for the filing of a bill of complaint and issuance of a subpoena to the employer.

F. A contest of the proposed penalty only shall not stay the time for abatement.

§ 6.3. General contest proceedings applicable to the public sector.

A. The commissioner will not propose penalties for citations issued to public employers.

B. Public employers may contest citations or abatement orders by notifying the commissioner in writing of the contest. The notice of contest must be mailed or delivered by hand within 15 working days from receipt of the citation or abatement order. No mistake, inadvertence, or neglect on the part of the employer shall serve to extend the 15 working day period during which the employer may contest.

C. The notice of contest shall indicate whether the employer is contesting the alleged violations or the abatement order.

D. Public employees may contest abatement orders by notifying the commissioner in the same manner as described at subsection B.

E. The commissioner shall seek to resolve any controversies or issues rising from a citation issued to any public employer in an informal conference as described in § 8.1 of these regulations.

F. The contest by a public employer shall not affect the requirements to post the citation as required at § 2.3 of these regulations unless and until the commissioner's or the court ruling on the contest vacates the citation. A contest of a citation may stay the time permitted for abatement pursuant to § 40.1-49.4 C of the Code of Virginia.

§ 6.4. Contest proceedings applicable to political subdivisions.

A. Where the informal conference has failed to resolve any controversies arising from the citation, and a timely notice of contest has been received regarding a citation issued to a public employer other than the Commonwealth or one of its agencies, the Commissioner of Labor and Industry shall schedule a hearing in accordance with the provisions of § 9-6.14:11 of the Code of Virginia. Upon conclusion of the hearing, the

commissioner will notify all participants within five working days of the decision to affirm, modify or vacate the contested aspects of the citation or abatement order.

B. Public employers may appeal decisions of the commissioner in the manner provided for in [§ 40.1-49.5 §§ 9-6.14:15 through 9-6.14:19] of the Code of Virginia.

C. Public employees and their authorized representative have full rights to notification and participation in all hearings and appeals as are given private sector employees.

D. If abatement of citations is not accomplished, the commissioner shall seek injunctive relief under § 40.1-49.4 F of the Code of Virginia.

§ 6.5. Contest proceedings applicable to the Commonwealth.

A. Where the informal conference has failed to resolve any controversies arising from a citation issued to the Commonwealth or one of its agencies, and a timely notice of contest has been received, the Commissioner of Labor and Industry shall refer the case to the Attorney General, whose written decision on the contested matter shall become a final order of the commissioner.

B. Whenever the Commonwealth or any of its agencies fails to abate a violation within the time provided in an appropriate final order, the Commissioner of Labor & Industry shall formally petition for redress as follows: For violations in the Department of Law, to the Attorney General; for violations in the Office of the Lieutenant Governor, to the Lieutenant Governor; for violations otherwise in the executive branch, to the appropriate cabinet secretary; for violations in the State Corporation Commission, to a judge of the commission; for violations in the Department of Workers' Compensation, to the Chairman of the Workers' Compensation Commission; for violations in the legislative branch of government, to the Chairman of the Senate Committee on Commerce and Labor; for violations in the judicial branch, to the chief judge of the circuit court or to the Chief Justice of the Supreme Court. Where the violation cannot be timely resolved by this petition, the commissioner shall bring the matter to the Governor for resolution.

C. Where abatement of a violation will require the appropriation of funds, the commissioner shall cooperate with the appropriate agency head in seeking such an appropriation; where the commissioner determines that an emergency exists, the commissioner shall petition the Governor for funds from the Civil Contingency Fund or other appropriate source.

PART VII. ABATEMENT.

§ 7.1. Contest of abatement period.

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A. The employer, employees, or employee representative may, by written notification to the commissioner, contest the time permitted for abatement.

B. The notice of contest of abatement period must be in writing and shall have been delivered by hand or mailed to the commissioner within 15 working days from the date of the receipt of the citation and order of abatement.

C. The same procedures and requirements used for contest of citation and penalty, set forth at §§ 6.2, 6.3, 6.4, and 6.5, of these regulations, shall apply to contests of abatement period.

D. The time permitted for abatement, if contested in good faith and not merely for delay, does not begin to run until the entry of a final order of the [circuit] court.

§ 7.2. Extension of abatement time.

A. Where an extension of abatement is sought concerning a final order of the commissioner or of a court, the extension can be granted as an exercise of the enforcement discretion of the commissioner. While the extension is in effect the commissioner will not seek to cite the employer for failure to abate [the] violation in question. The employer shall carry the burden of proof to show that an extension should be granted.

B. The commissioner will consider a written petition for an extension of abatement time if the petition is mailed to or received by the commissioner prior to the expiration of the established abatement time.

C. A written petition requesting an extension of abatement time shall include the following information:

1. All steps taken by the employer, and the dates such actions were taken, in an effort to achieve compliance during the prescribed abatement period;
2. The specific additional abatement time necessary in order to achieve compliance;
3. The reasons such additional time is necessary, such as the unavailability of professional or technical personnel or of materials and equipment, or because necessary construction or alteration of facilities cannot be completed by the original abatement date;
4. All available interim steps being taken to safeguard the employees against the cited hazard during the abatement period; and
5. A certification that a copy of the petition has been posted and served on the authorized representative of affected employees, if there is one, in accordance with § 2.3 of these regulations, and a certification of the date upon which such posting and service was made.

D. A written petition requesting an extension of

abatement which is [file filed] with the commissioner after expiration of the established abatement time will be accepted only if the petition contains an explanation satisfactory to the commissioner as to why the petition could not have been filed in a timely manner.

1. The employer is to notify the commissioner as soon as possible.

2. Notification of the exceptional circumstances which prevents compliance within the original abatement period shall accompany a written petition which includes all information required in subsection C.

E. The commissioner will not make a decision regarding such a petition until the expiration of 15 working days from the date the petition was posted or served.

F. Affected employees, or their representative, may file a written objection to a petition for extension of abatement time. Such objections must be received by the commissioner within 10 working days of the date of posting of the employer's petition. Failure to object within the specified time period shall constitute a waiver of any right to object to the request.

G. When affected employees, or their representatives object to the petition, the commissioner will attempt to resolve the issue in accordance with § 8.1 of these regulations. If the matter is not settled or settlement does not appear probable, the Commissioner of Labor and Industry will hear the objections in the manner set forth at subsection I below.

H. The employer or an affected employee may seek review of an adverse decision regarding the petition for extension of abatement to the Commissioner of Labor and Industry within five working days after receipt of the commissioner's decision.

I. An employee's objection not resolved under subsection G of this section or an employer or employee appeal under subsection H will be heard by the Commissioner of Labor and Industry using the procedures of § 9-6.14:11 of the Code of Virginia. Burden of proof for a hearing under subsection G shall lie with the employer. Burden of proof for an appeal under subsection H shall lie with the party seeking review.

1. All parties shall be advised of the time and place of the hearing by the commissioner.

2. Within 15 working days of the hearing, all parties will be advised of the Commissioner of Labor and Industry's decision.

3. Since the issue is whether the Commissioner of Labor and Industry will exercise his enforcement discretion, no further appeal is available.

PART VIII.

REVIEW AND SETTLEMENT.

§ 8.1. Informal conference.

A. An informal conference may be held for the purpose of discussing any issue raised by the inspection, citation, abatement order, proposed penalty, notice of contest, or any other disputed issue.

B. The employer, an employee, or an employee representative may request an informal conference. Neither the conference nor a request for a conference shall stay the running of time allowed for abatement of a cited violation or the time allowed for filing a notice of contest of the citation, abatement period or proposed penalty.

C. The informal conference will be held by the commissioner. However, other personnel of the Department of Labor and Industry, Department of Health, and any other state department or agency may participate as deemed necessary.

D. The time and location of the informal conference shall be at the discretion of the commissioner, except that the conference shall not be held at the employer's work site.

E. An employee representative shall be given the opportunity to participate in a conference requested by the employer. This same right will be extended to the employer when an informal conference is requested by employees. It is the duty of the employer, if he has requested a conference, to notify the employees by the means described in § 2.3 of these regulations as soon as the time and place of the conference have been established. Upon granting an employee request for a conference, the commissioner is responsible for notifying the employer. The commissioner, at his discretion, may conduct separate portions of the conference with the employer and employee representative.

F. During or following the conference the commissioner may affirm or amend the citations, penalties, or abatement period if the order has not become final. The commissioner shall notify the employer in writing of his decision. The employer shall notify employees of this decision in the manner set forth in § 2.3 of these regulations.

G. The failure to request an informal conference before the expiration of 15 working days does not preclude settlement at a later stage of the proceedings if a notice of contest has been timely filed.

§ 8.2. Settlement.

A. Settlement negotiations may be held for the purpose of resolving any dispute regarding an inspection, citation, order of abatement, proposed penalty, or any other matter involving potential litigation. Settlement is encouraged at

any stage of a proceeding until foreclosed by an order becoming final. It is the policy of the commissioner that the primary goal of all occupational safety and health activity is the protection of worker safety, health and welfare; all settlements shall be guided by this policy.

B. Settlement negotiations will ordinarily take place in the medium of an informal conference. Employees shall be given notice of scheduled settlement discussions and shall be given opportunity to participate in the manner provided for in § 8.1 E of these regulations.

C. Where a settlement with the employer is reached before the 15th working day after receipt of a citation, order of abatement, or proposed civil penalty, and no notice of contest has been filed, the commissioner shall forthwith amend the citation, order of abatement, or proposed civil penalty, as agreed. The amended citation shall bear a title to indicate that it has been amended and the amended citation or an accompanying agreement shall contain a statement to the following effect: "This citation has been amended by agreement between the commissioner and the employer named above. As part of the written agreement, the employer has waived his right to file a notice of contest to this order. This agreement shall not be construed as an admission by the employer of civil liability for any violation alleged by the commissioner."

D. Following receipt of an employer's timely notice of contest, the commissioner will immediately notify the appropriate Commonwealth's Attorney and may delay the initiation of judicial proceedings until settlement opportunities have been exhausted.

1. During this period, the commissioner may amend the citation, order of abatement, or proposed civil penalty through the issuance of an amended citation. Every such amended citation shall bear a title to indicate that it has been amended and the amended citation or the accompanying agreement shall contain a statement to the following effect: "This amended citation is being issued as a result of a settlement between the commissioner and the employer. The employer, by his signature below, agrees to withdraw his notice of contest filed in this matter and not to contest the amended citation. This agreement shall not be construed as an admission by the employer of civil liability for any violation alleged by the commissioner."

2. At the end of this period, if settlement negotiations are not successful, the commissioner will initiate judicial proceedings by causing a bill of complaint to be filed and turning over the contested case to the Commonwealth's Attorney.

E. Employees or their representative have the right to contest abatement orders arising out of settlement negotiations if the notice is timely filed with the commissioner within 15 working days of issuance of the

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amended citation and abatement order. Upon receipt of a timely notice of contest the commissioner will initiate judicial proceedings.

F. After a bill of complaint has been filed, any settlement shall be handled through the appropriate Commonwealth's Attorney and shall be embodied in a proposed order and presented for approval to the court before which the matter is pending. Every such order shall bear the signatures of the parties or their counsel; shall provide for abatement of any violation for which the citation is not vacated; shall provide that the employer's agreement not be construed as an admission of civil liability; and may permit the commissioner, when good cause is shown by the employer, to extend any abatement period contained within the order.

VA.R. Doc. No. R94-974; Filed May 11, 1994, 10:47 a.m.

* * * * *

REGISTRAR'S NOTICE: The following regulation filed by the Department of Labor and Industry is excluded from Article 2 of the Administrative Process Act in accordance with § 9-6.14:4.1 C 4(c) of the Code of Virginia, which excludes regulations that are necessary to meet the requirements of federal law or regulations, provided such regulations do not differ materially from those required by federal law or regulation. The Safety and Health Codes Board will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: VR 425-02-98. Occupational Safety and Health Standard for Cadmium in Shipyard Employment (1915.1027).

Statutory Authority: § 40.1-22(5) of the Code of Virginia.

Effective Date: July 1, 1994.

Summary:

The Occupational Safety and Health Standard for Cadmium in Shipyard Employment established a single eight-hour time-weighted average (TWA) permissible exposure limit (PEL) of five micrograms of cadmium per cubic meter (ug/m3) of air for all cadmium compounds, including dust and fumes. Employers are required to comply with this limit primarily by means of engineering and work practice controls. For a small number of industries, federal OSHA has also established a separate engineering control air limit (SECAL) of 25 ug/m3 as the lowest feasible level above the PEL that can be achieved by engineering and work practice controls.

The SECAL, like the PEL for other industries, must be achieved by engineering and work practice controls except to the extent that the employer can

demonstrate that such controls are not feasible.

The standard requires the following:

- 1. Establishment of an eight-hour time-weighted average (TWA) permissible exposure limit (PEL) of five micrograms of cadmium (any form) per cubic meter air (5 ug/m3) for all cadmium compounds, including dust and fumes.*
- 2. Establishment of an action level of 2.5 ug/m3 as the level at and above which employers must initiate certain compliance activities, such as exposure monitoring and medical surveillance. Where the employer can demonstrate that the exposures of his or her employees do not exceed the action level, the employer is not obligated to comply with any of the standard's requirements other than provisions for training workers about the hazards of cadmium.*
- 3. Regulated areas.*
- 4. Engineering and work practice controls.*
- 5. Written compliance programs.*
- 6. Respiratory protection.*
- 7. Written action plan in emergency situations.*
- 8. Protective work clothing and equipment.*
- 9. Hygiene facilities and practices.*
- 10. Housekeeping practices.*
- 11. Medical surveillance.*
- 12. Hazard communication.*
- 13. Recordkeeping.*

Note on Incorporation By Reference

Pursuant to § 9-6.18 of the Code of Virginia, the Occupational Safety and Health Standards for Cadmium in Shipyard Employment (1915.1027) is declared a document generally available to the public and appropriate for incorporation by reference. For this reason the entire document will not be printed in The Virginia Register of Regulations. Copies of the document are available for inspection at the Department of Labor and Industry, 13 South 13th Street, Richmond, Virginia, and in the Office of the Registrar of Regulations, General Assembly Building, Capitol Square, Room 262, Richmond, Virginia.

On April 25, 1994, the Safety and Health Codes Board adopted an identical version of federal OSHA's final rule entitled, "Occupational Safety and Health Standards for Cadmium in Shipyard Employment," 29 CFR § 1915.1027, as published in the Federal Register, Vol. 59, No. 1, pp. 147-215, Monday, January 3, 1994. The standards as adopted are not set out.

When the regulations, as set forth in the Occupational

Safety and Health Standard for Cadmium in Shipyard Employment, § 1915.1027, and its corrections and technical amendments, are applied to the Commissioner of the Department of Labor and Industry or to Virginia employers, the following federal terms shall be considered to read as follows:

<u>Federal Terms</u>	<u>VOSH Equivalent</u>
Assistant Secretary 29 CFR 1915.1027	Commissioner of Labor and Industry 1915.1027

Implementation Schedule

Adoption date	4/25/94
Effective date	7/01/94
Exposure Monitoring [1915.1027(d)(2)]	8/30/94
For small businesses [19 or fewer employees]	10/29/94
Regulated areas [1915.1027(e)]	9/29/94
For small businesses	11/28/94
Respiratory protection [1915.1027(g)]	9/29/94
For small businesses	11/28/94
Compliance program [1915.1027(f)(2)]	7/01/95
Methods of compliance- engineering controls [1915.1027(f)(1)]	7/01/96
Hygiene and lunchroom facilities	
Handwashing facilities [1915.1027(d)(1) and (2)]	8/30/94
Change rooms, showers, lunchroom facilities [1915.1027(d)(1)]	7/01/95
Employee information and training [1915.1027(m)(4)]	9/29/94
For small businesses	12/28/94
Medical surveillance [1915.1027(l)]	9/29/94
For small businesses [1910.1027(l)]	12/28/94

VA.R. Doc. No. R94-943; Filed May 2, 1994, 10:52 a.m.



COMMONWEALTH of VIRGINIA

JOAN W. SMITH
REGISTRAR OF REGULATIONS

VIRGINIA CODE COMMISSION
General Assembly Building

310 CAPITOL STREET
RICHMOND, VIRGINIA 23219
(804) 786-3251

May 11, 1994

Mr. Linwood Saunders, Chairman
Virginia Safety and Health Codes Board
c/o Mr. John J. Crisanti, Director
Office of Enforcement Policy
The Department of Labor and Industry
13 South Thirteenth Street
Richmond, Virginia 23219

RE: VR 425-02-98 Occupational Safety and Health Standard for
Cadmium in Shipyard Employment, 1915.1027

Dear Mr. Saunders:

This will acknowledge receipt of the above-referenced regulations from the Department of Labor and Industry.

As required by § 9-6.14:4.1 C.4.(c). of the Code of Virginia, I have determined that these regulations are exempt from the operation of Article 2 of the Administrative Process Act, since they do not differ materially from those required by federal law.

Sincerely,

Joan W. Smith
Registrar of Regulations

TWS:jbc

Final Regulations

REGISTRAR'S NOTICE: The following regulation filed by the Department of Labor and Industry is excluded from Article 2 of the Administrative Process Act in accordance with § 9-6.14:4.1 C 4(c) of the Code of Virginia, which excludes regulations that are necessary to meet the requirements of federal law or regulations, provided such regulations do not differ materially from those required by federal law or regulation. The Safety and Health Codes Board will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: VR 425-02-99. Agriculture Industry Standard for Applicable Standards in 29 CFR 1910 (1928.21).

Statutory Authority: § 40.1-22(5) of the Code of Virginia.

Effective Date: July 1, 1994.

Summary:

The amendment to the existing Hazard Communication Standard includes a number of minor changes and technical corrections to further clarify the requirements and thereby help ensure full compliance and achieve protection for employees. In general, the change adds and clarifies certain exemptions from labeling and other requirements; modifies and clarifies aspects of the written hazard communication program and labeling requirements; clarifies and slightly modifies the duties of distributors, manufacturers and importers to provide material safety data sheet (MSDSs) to employees; and clarifies certain provisions regarding MSDSs.

Note on Incorporation By Reference

Pursuant to § 9-6.18 of the Code of Virginia, the Agriculture Industry Standard for Applicable Standards in 29 CFR 1910 (1928.21) is declared a document generally available to the public and appropriate for incorporation by reference. For this reason the entire document will not be printed in The Virginia Register of Regulations. Copies of the document are available for inspection at the Department of Labor and Industry, 13 South 13th Street, Richmond, Virginia, and in the Office of the Registrar of Regulations, General Assembly Building, Capitol Square, Room 262, Richmond, Virginia.

On April 25, 1994, the Safety and Health Codes Board adopted an identical version of federal OSHA's Agriculture Industry Standard for Applicable Standards in 29 CFR 1910, 29 CFR 1928.21, as published in the Federal Register, Vol. 59, No. 27, pp. 6169-6184, Wednesday, February 9, 1994. The standard as adopted is not set out.

When the regulations, as set forth in the Agriculture Industry Standard for Applicable Standards in 29 CFR 1910, § 1928.21, are applied to the Commissioner of the Department of Labor and Industry or to Virginia employers, the following federal terms shall be considered to read as follows:

Federal Terms

29 CFR
Assistant Secretary
March 11, 1994

VOSH Equivalent

VOSH Standard
Commissioner of Labor and Industry
July 1, 1994

VA.R. Doc. No. R94-942; Filed May 2, 1994, 10:53 a.m.



COMMONWEALTH of VIRGINIA

JOAN W. SMITH
REGISTRAR OF REGULATIONS

VIRGINIA CODE COMMISSION
General Assembly Building

510 CAPITOL STREET
RICHMOND, VIRGINIA 23219
(804) 786-3551

May 11, 1994

Mr. Linwood Saunders, Chairman
Virginia Safety and Health Codes Board
c/o Mr. John J. Crisanti, Director
Office of Enforcement Policy
The Department of Labor and Industry
13 South Thirteenth Street
Richmond, Virginia 23219

RE: VR 425-02-99 Amendment to the Agriculture Standard.
Applicable Standards in 29 CFR 1910, 1928.21

Dear Mr. Saunders:

This will acknowledge receipt of the above-referenced regulations from the Department of Labor and Industry.

As required by § 9-6.14:4.1 C.4.(c) of the Code of Virginia, I have determined that these regulations are exempt from the operation of Article 2 of the Administrative Process Act, since they do not differ materially from those required by federal law.

Sincerely,

Joan W. Smith
Joan W. Smith
Registrar of Regulations

JWS:jbc

* * * * *

Title of Regulation: VR 425-02-101. Public Participation Guidelines.

Statutory Authority: §§ 9-6.14:7.1 and 40.1-22(5) of the Code of Virginia.

Effective Date: July 1, 1994.

Summary:

Section 9-6.14:7.1 of the Code of Virginia requires each agency to develop, adopt and use Public Participation Guidelines for soliciting comments from interested parties when developing, revising, or repealing regulations. Agency is defined in the Administrative Process Act as "any authority, instrumentality, officer, board or other unit of the state government empowered by the basic laws to make regulations or decide cases." Legislation enacted by the 1993 General Assembly amended the Administrative Process Act (APA) by adding additional provisions to be included in agency Public Participation Guidelines.

Public Participation Guidelines were adopted by the Safety and Health Codes Board on September 19, 1984. Emergency Public Participation Guidelines which included the new requirements were adopted by the board June 21, 1993, and were effective June 30, 1993.

The Public Participation Guidelines of the Safety and Health Codes Board set out procedures to be followed by the board and the Department of Labor and Industry which ensure that the public and all parties interested in regulations adopted by the board have a full and fair opportunity to participate at every stage in the development or revision of regulations.

The regulation sets forth processes to identify interested groups, to involve the public in the formulation of regulations, and to solicit and use public comments and suggestions. For regulations adopted by the board which are subject to the Administrative Process Act, the regulation sets forth procedures to issue Notices of Intended Regulatory Action, and to draft and adopt regulations. It also defines the role of advisory groups and the use of open meetings. The regulation also provides a procedure to notify the public of proposed federal Occupational Safety and Health Administration regulatory action and encourages the public's participation in the formulation of these regulations at the federal level.

Summary of Public Comment and Agency Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the office of the Registrar of

Regulations.

Agency Contact: Copies of the regulation may be obtained from Bonnie H. Robinson, Department of Labor and Industry, 13 South 13th Street, Richmond, VA 23219, telephone (804) 371-2631. There may be a charge for copies.

VR 425-02-101. Public Participation Guidelines.

**PART I.
DEFINITIONS.**

§ 1.1. Definitions.

The following words and terms, when used in these regulations, shall have the following meaning, unless the context clearly indicates otherwise:

"Ad hoc advisory group" means a task force to develop a new regulation, or review current regulations, or revise current regulations, or advise the board on particular issues under consideration for regulation.

"Administrative Process Act" means Chapter 1.1:1 (§ 9-6.14:1 et seq.) of Title 9 of the Code of Virginia.

"Board" means the Virginia Safety and Health Codes Board.

"Commissioner" means the Commissioner of Labor and Industry or his designee.

"Department" means the Virginia Department of Labor and Industry.

"Locality particularly affected" means any locality which bears any identified disproportionate material impact which would not be experienced by other localities.

"Open meeting" means an informal meeting to provide an opportunity for the board or their designee to hear information, receive views and comments, and to answer questions presented by the public on a particular issue or regulation under consideration by the board. It is a meeting to facilitate the informal exchange of information and may be held prior to or during the regulation promulgation process.

"OSHA" means the Occupational Safety and Health Administration, U.S. Department of Labor.

"Public hearing" means an informational proceeding conducted pursuant to § 9-6.14:7.1 of the Code of Virginia.

"Regulation" means any statement of general application, having the force of law, affecting the rights or conduct of any person, promulgated by the board in accordance with the authority conferred upon it by applicable basic law.

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"Secretary" means the Secretary of Commerce and Trade or his designee.

PART II. GENERAL INFORMATION.

§ 2.1. Applicability.

These guidelines shall apply to all regulations subject to the Administrative Process Act which are adopted by the Virginia Safety and Health Codes Board and administered by the Commissioner of Labor and Industry. They shall not apply to regulations adopted on an emergency basis. This regulation does not apply to regulations exempted from the provisions of the Administrative Process Act (§ 9-6.14:4.1 A and B) or excluded from the operation of Article 2 of the Administrative Process Act (§ 9-6.14:4.1 C).

§ 2.2. Purpose.

The purpose of these guidelines is to ensure that the public and all parties interested in the regulations have a full and fair opportunity to participate at every stage in the development or revision of the regulations.

The failure of any person to receive any notice or copies of any documents provided under these guidelines shall not affect the validity of any regulation otherwise adopted in accordance with this regulation.

At the discretion of the board, the procedures in Part III or Part IV may be supplemented to provide additional public participation in the regulation adoption process or as necessary to meet federal requirements.

§ 2.3. Identification of interested persons and groups.

The major groups interested in the regulatory process of the board are:

1. Business and labor associations and organizations such as the Virginia Manufacturers Association and the Virginia State AFL-CIO;
2. Persons, groups, businesses, industries, and employees affected by the specific regulation who have previously expressed an interest by writing or participating in public hearings; and
3. Persons or groups who have asked to be placed on a mailing list.

§ 2.4. Public involvement with formulation of regulations.

A. The board shall accept petitions to develop a new regulation or amend an existing regulation from any member of the public. The board shall consider the petition and provide a response within 180 days.

B. The petition, at a minimum, shall contain the following information:

1. Name, mailing address and telephone number of petitioner;
2. Petitioner's interest in the proposed action;
3. Recommended regulation or addition, deletion or amendment to a specific regulation;
4. Statement of need and justification for the proposed action;
5. Statement of impact on the petitioner and other affected persons; and
6. Supporting documents, as applicable.

PART III. PUBLIC PARTICIPATION PROCEDURES.

§ 3.1. Advisory groups and consultation.

A. The board may form a standing or ad hoc advisory group to make recommendations on a proposed regulation. When an ad hoc advisory group is formed, it shall include representatives from the interested persons or groups identified in § 2.3. The membership of any ad hoc advisory group shall be selected by the board or, at the board's option, by a committee of board members or, at the direction of the board, by the commissioner.

B. Ad hoc advisory groups or consultation with groups or individuals will be used when the regulation proposed is unique to Virginia or more stringent than existing federal regulations.

C. Ad hoc advisory groups or consultation with groups or individuals may be used when:

1. The proposed regulation is of wide general impact;
2. The proposed regulation is of wide general interest to the public;
3. The subject of the regulation has not been regulated previously by the board;
4. The board determines this is the most effective method to develop the regulation; or
5. The board determines additional technical expertise and knowledge would be beneficial in developing the regulation.

§ 3.2. Open meetings.

The board may schedule an open meeting or meetings to provide information and to receive views and comments and answer questions from the public. The meeting(s) will normally be held at locations throughout the Commonwealth, but if the proposed regulation will apply only to a particular area of the state, it will be

held in the affected area. These meetings may be held prior to the beginning of the formal regulatory process or during the Notice of Intended Regulatory Action period or during the 60-day comment period on proposed regulations and will be in addition to any public hearing.

§ 3.3. Notice of Intended Regulatory Action (NOIRA).

A. The department, at the direction of the board, will identify persons or groups, as referred to in § 2.3, interested in the development of the regulation and assemble the appropriate mailing list.

B. The board shall issue a NOIRA whenever it intends to consider the development, amendment or repeal of any regulation. The NOIRA will include:

1. Subject of the proposed regulation.
2. Identification of the persons or groups affected.
3. Summary of the purpose of the proposed regulation and the issues involved.
4. Listing of applicable laws or regulations, and locations where these documents can be reviewed or obtained.
5. Explanation of federal requirements for adoption and specific obligations of the board, if applicable.
6. Request for comments from interested parties and deadline for receipt of the written comments.
7. Notification of time and place of open meeting(s), if the board intends to hold open meetings.
8. Name, address and telephone number of staff person to be contacted for further information.
9. Statement that the board intends to hold a public hearing on the proposed regulation after it is published.

C. If appropriate, the board will appoint an advisory group as outlined in § 3.1.

D. The NOIRA will be disseminated to the public via:

1. Distribution by mail, facsimile or other appropriate delivery method to persons on the appropriate mailing list.
2. Publication in *The Virginia Register of Regulations*.
3. Publication in a newspaper of statewide circulation.
4. Publication in newspaper(s) in localities particularly affected by the regulation. The localities particularly affected have been identified by the department at the direction of the board.

§ 3.4. Proposed regulations.

A. After consideration of public comment, the board may prepare a proposed draft regulation and any necessary documentation required for review. If an ad hoc advisory group has been established, the draft regulation shall be developed in consultation with such group.

B. The commissioner, at the direction of the board, will present the proposed draft to the secretary's office for review and concurrence prior to the formal adoption by the board and the beginning of the 60-day public comment period.

C. The board will submit the proposed regulation to a 60-day public hearing/comment period by forwarding the following documents to the Registrar of Regulations by the established submission date for the desired date of publication in *The Virginia Register* and the beginning of the 60-day comment period:

1. Notice of public hearing/comment period, which will contain the following:
 - a. The date, time and place of the public hearing. (Public hearing is defined in this regulation.)
 - b. The legal authority of the board to act.
 - c. The name, address and telephone number of an individual to contact for further information and where to submit written comments.
2. Full text of the regulation.
3. Summary of the regulation.
4. Statement of the basis of the regulation, defined as the statutory authority for promulgating the regulation, including an identification of the section number and a brief statement relating the content of the statutory authority to the specific regulation proposed.
5. Statement of the purpose of the regulation, defined as the rationale or justification for the provisions of a new regulation or changes to an existing regulation, from the standpoint of the public's health, safety or welfare.
6. Statement of the substance of the regulation, defined as the identification and explanation of the key provisions of the regulation.
7. Statement of the issues of the regulations, defined as the primary advantages and disadvantages for the public, and as applicable for the department or the state, of implementing the new or amended regulatory provisions.
8. Statement of the estimated impact, defined as the

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projected number of persons affected, the projected costs, expressed as a dollar figure or range, for the implementation and compliance with the new regulation or amendments, and the identity of any localities particularly affected by the regulation. The estimated impact shall represent the board's best estimate for the purposes of public review and comment, but the accuracy of the estimate shall in no way affect the validity of the regulation.

9. A copy of the written assurance from the Office of the Attorney General which states that the board has the statutory authority to issue the proposed regulation.

10. An explanation of how clarity and simplicity were assured in drafting the regulations.

11. A statement describing the alternative approaches that were considered to meet the need the proposed regulations address, and assurance that the proposed regulations are the least burdensome available alternative.

12. A schedule setting forth when, after the effective date of the regulation, the board will evaluate it for effectiveness and continued need.

D. Concurrently with the preceding step, the board will submit required documentation to the Governor's office, the Department of Planning and Budget, and the Office of the Secretary of Commerce and Trade.

E. Upon receipt of the proposed regulation and appropriate documentation, the Registrar of Regulations will publish the summary of the regulation and the public hearing notice in The Virginia Register and in a Richmond area newspaper of general circulation. If applicable, the department will request that the Registrar publish the notice in newspapers in other areas of the state. The department will mail a copy of the notice to persons and groups on the appropriate mailing list.

F. During the public comment period, the regulation will be available for review concurrently by the following:

1. The public.
2. The Governor.
3. The General Assembly.
4. The Secretary of Commerce and Trade, and
5. The Attorney General.

§ 3.5. Completion of the adoption process.

A. The board shall prepare a summary of the oral and written comments received during the 60-day public comment period and the board's response to the

comments. A draft of the board's summary shall be sent to all parties who commented on the proposed regulation. The summary shall be sent at least five days before final adoption of the regulation.

B. At the end of the 60-day public comment period, the department shall prepare the final proposed regulation.

C. The final regulation shall be submitted to the board for adoption.

D. The board shall submit the final regulation to the Registrar of Regulations for publication in The Virginia Register at least 30 days prior to the effective date of the regulation.

E. The following documents shall be sent to the Registrar's office. Concurrently, these documents shall be sent to the Governor's office, the Department of Planning and Budget, and the Office of the Secretary of Commerce and Trade.

1. A copy of the final regulation.
2. A current summary and statement as to the basis, purpose, substance, issues, and impact of the regulation.
3. The summary of the oral and written comments received during the 60-day public comment period and the board's response to the comments.

PART IV.

OCCUPATIONAL SAFETY AND HEALTH STANDARDS PROMULGATED BY THE U. S. OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION.

§ 4.1. General.

The Virginia State Plan for the enforcement of occupational safety and health laws commits the state to adopt regulations that shall be at least as stringent as the standards promulgated by the U. S. Department of Labor, Occupational Safety and Health Administration.

Accordingly, participation in the formulation of such regulations must occur during the adoption of the regulations at the federal level. To encourage such participation the following actions will be taken.

§ 4.2. Notice of proposed federal regulatory action.

A. When advised of proposed federal regulatory action, the board will prepare a general notice of the proposed federal regulatory action for publication in The Virginia Register. The general notice will include:

1. Subject of the proposed regulation.
2. Summary of the issue involved and purpose of the

proposed regulation.

3. Timetable for submitting written comments or notification of desire to be heard at hearing or both.

4. Time and place of public hearing.

5. Request that comments be submitted to OSHA with a copy to the Virginia Department of Labor and Industry.

6. Name and address of contact at OSHA.

7. Copy of proposed regulation.

B. The notice will be disseminated to the appropriate persons or groups identified and placed on a mailing list assembled in accordance with § 2.3 of these guidelines.

VA.R. Doc. No. R94-968; Filed May 11, 1994, 10:50 a.m.

* * * * *

REGISTRAR'S NOTICE: The following regulation filed by the Department of Labor and Industry is excluded from Article 2 of the Administrative Process Act in accordance with § 9-6.14:4.1 C 4(c) of the Code of Virginia, which excludes regulations that are necessary to meet the requirements of federal law or regulations, provided such regulations do not differ materially from those required by federal law or regulation. The Safety and Health Codes Board will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: VR 425-02-151. Personal Protective Equipment, General Industry (1910.132 through 1910.140).

Statutory Authority: § 40.1-22(5) of the Code of Virginia.

Effective Date: July 5, 1994.

Summary:

These amendments to the existing Subpart I, Personal Protective Equipment (PPE), include standards containing general requirements for all PPE under 1910.132 and other standards that set design, selection, and use requirements for specific types of PPE (eye, face, head, foot and hand).

Federal OSHA has updated the standards for PPE to be more consistent with the current consensus regarding good industry practices, as reflected by the latest editions of the pertinent American National Standards Institute (ANSI) standards. These revisions will provide guidance for the selection and use of PPE as well as clearer requirements, when appropriate, that are performance oriented.

New paragraphs (d), (e) and (f) have been added to

1910.132. These paragraphs contain requirements covering equipment selection, defective and damaged equipment, and training, respectively. Also, a new section, 1910.138, has been added to this subpart to address hazards to the hands. Nonmandatory Appendices A and B have also been added to this subpart to provide additional guidance to employers and employees with regard to PPE for eye, face, head, foot and hand hazards.

Note on Incorporation By Reference

Pursuant to § 9-6.18 of the Code of Virginia, Subpart I of the General Industry Standards for Personal Protective Equipment (1910.132 through 1910.140) is declared a document generally available to the public and appropriate for incorporation by reference. For this reason the entire document will not be printed in The Virginia Register of Regulations. Copies of the document are available for inspection at the Department of Labor and Industry, 13 South 13th Street, Richmond, Virginia, and in the Office of the Registrar of Regulations, General Assembly Building, Capitol Square, Room 262, Richmond, Virginia.

On April 25, 1994, the Safety and Health Codes Board adopted an identical version of federal OSHA's amendments to Subpart I, General Industry Standards for Personal Protective Equipment entitled, "General Requirement," 29 CFR 1910.132; "Eye and Face Protection," 29 CFR 1910.133; "Foot Protection," 29 CFR 1910.135; "Head Protection," 29 CFR 1910.136; and the new standard, "Hand Protection," 29 CFR 1910.138 as jointly published in the Federal Register, Vol. 59, No. 66, pp. 16360-16364, Wednesday, April 6, 1994. The amendments as adopted are not set out.

When the regulations, as set forth in the standards for Personal Protective Equipment, General Industry, §§ 1910.132 through 1910.140, are applied to the Commissioner of the Department of Labor and Industry or to Virginia employers, the following federal terms shall be considered to read as follows:

Federal Terms	VOSH Equivalent
29 CFR 1910.132	1910.132
29 CFR 1910.133	1910.133
29 CFR 1910.135	1910.135
29 CFR 1910.136	1910.136
29 CFR 1910.138	1910.138
Assistant Secretary	Commissioner of Labor and Industry
July 5, 1994	July 5, 1994

VA.R. Doc. No. R94-941; Filed May 2, 1994, 10:53 a.m.

Final Regulations



COMMONWEALTH of VIRGINIA

JOAN W. SMITH
REGISTRAR OF REGULATIONS

VIRGINIA CODE COMMISSION
General Assembly Building

910 CAPITOL STREET
RICHMOND, VIRGINIA 23219
(804) 789-3291

May 11, 1994

Mr. Linwood Saunders, Chairman
Virginia Safety and Health Codes Board
c/o Mr. John J. Crisanti, Director
Office of Enforcement Policy
The Department of Labor and Industry
13 South Thirteenth Street
Richmond, Virginia 23219

RE: VR 425-02-151, Personal Protective Equipment,
General Industry, 1910.132-1910.140

Dear Mr. Saunders:

This will acknowledge receipt of the above-referenced regulations from the Department of Labor and Industry.

As required by 5 9-5.14:4.1 C.4.(c) of the Code of Virginia, I have determined that these regulations are exempt from the operation of Article 2 of the Administrative Process Act, since they do not differ materially from those required by federal law.

Sincerely,

Joan W. Smith
Registrar of Regulations

JWS:jbc

Final Regulations

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REGISTRAR'S NOTICE: The following regulation filed by the Department of Labor and Industry is excluded from Article 2 of the Administrative Process Act in accordance with § 9-6.14:4.1 C 4(c) of the Code of Virginia, which excludes regulations that are necessary to meet the requirements of federal law or regulations, provided such regulations do not differ materially from those required by federal law or regulation. The Safety and Health Codes Board will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: VR 425-02-173. Shipyard Employment Standard for Hazard Communication (1915.1200).

Statutory Authority: § 40.1-22(5) of the Code of Virginia.

Effective Date: July 1, 1994.

Summary:

The purpose of the Hazard Communication Standard is to ensure that the hazards of all chemicals produced or imported are evaluated, and that information concerning their hazards is transmitted to employers and employees. The standard uses a three-pronged approach. First, chemical manufacturers and importers must review available scientific evidence concerning the physical and health hazards of the chemicals they produce or import to determine if they are hazardous. Second, for every chemical found to be hazardous, the chemical manufacturer or importer must develop comprehensive material safety data sheets and warning labels for containers and send both downstream along with the chemicals. Third, all employers must develop a written hazard communication program and provide information and training to employees about the hazardous chemicals in their workplace.

Note on Incorporation By Reference

Pursuant to § 9-6.18 of the Code of Virginia, the Shipyard Employment Standard for Hazard Communication (1915.1200) is declared a document generally available to the public and appropriate for incorporation by reference. For this reason the entire document will not be printed in The Virginia Register of Regulations. Copies of the document are available for inspection at the Department of Labor and Industry, 13 South 13th Street, Richmond, Virginia, and in the Office of the Registrar of Regulations, General Assembly Building, Capitol Square, Room 262, Richmond, Virginia.

On April 25, 1994, the Safety and Health Codes Board adopted an identical version of federal OSHA's Shipyard Employment Standard for Hazard Communication, 29 CFR 1915.1200, as published in the Federal Register, Vol. 59, No. 27, pp. 6169-6184, Wednesday, February 9, 1994. The standard as adopted is not set out.

When the regulations, as set forth in the Shipyard Employment Standard for Hazard Communication, § 1915.1200, are applied to the Commissioner of the

Department of Labor and Industry or to Virginia employers, the following federal terms shall be considered to read as follows:

Federal Terms	VOSH Equivalent
29 CFR	VOSH Standard
Assistant Secretary	Commissioner of Labor and Industry
March 11, 1994	July 1, 1994

V.A.R. Doc. No. R94-940; Filed May 2, 1994, 10:54 a.m.



COMMONWEALTH of VIRGINIA

JOAN W. SMITH
REGISTRAR OF REGULATIONS

VIRGINIA CODE COMMISSION
General Assembly Building

310 CAPITOL STREET
RICHMOND, VIRGINIA 23219
(804) 788-3281

May 11, 1994

Mr. Linwood Saunders, Chairman
Virginia Safety and Health Codes Board
c/o Mr. John J. Crisanti, Director
Office of Enforcement Policy
The Department of Labor and Industry
13 South Thirteenth Street
Richmond, Virginia 23219

RE: VR 425-02-173, Shipyard Employment Standard
for Hazard Communication, 1915.1200

Dear Mr. Saunders:

This will acknowledge receipt of the above-referenced regulations from the Department of Labor and Industry.

As required by § 9-6.14:4.1 C.4.(c) of the Code of Virginia, I have determined that these regulations are exempt from the operation of Article 2 of the Administrative Process Act, since they do not differ materially from those required by federal law.

Sincerely,

Joan W. Smith
Registrar of Regulations

JWS:jbs

REGISTRAR'S NOTICE: The following regulation filed by the Department of Labor and Industry is excluded from Article 2 of the Administrative Process Act in accordance with § 9-6.14:4.1 C 4(c) of the Code of Virginia, which excludes regulations that are necessary to meet the requirements of federal law or regulations, provided such regulations do not differ materially from those required by federal law or regulation. The Safety and Health Codes Board will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: VR 425-02-174. Longshoring Standard for Hazard Communication (1918.90).

Statutory Authority: § 40.1-22(5) of the Code of Virginia.

Effective Date: July 1, 1994.

Summary:

The purpose of the Hazard Communication Standard is to ensure that the hazards of all chemicals produced or imported are evaluated, and that information concerning their hazards is transmitted to employers and employees. The standard uses a three-pronged approach. First, chemical manufacturers and importers must review available scientific evidence concerning the physical and health hazards of the chemicals they produce or import to determine if they are hazardous. Second, for every chemical found to be hazardous, the chemical manufacturer or importer must develop comprehensive material safety data sheets and warning labels for containers and send both downstream along with the chemicals. Third, all employers must develop a written hazard communication program and provide information and training to employees about the hazardous chemicals in their workplace.

Note on Incorporation By Reference

Pursuant to § 9-6.18 of the Code of Virginia, the Longshoring Standard for Hazard Communication (1918.90) is declared a document generally available to the public and appropriate for incorporation by reference. For this reason the entire document will not be printed in The Virginia Register of Regulations. Copies of the document are available for inspection at the Department of Labor and Industry, 13 South 13th Street, Richmond, Virginia, and in the Office of the Registrar of Regulations, General Assembly Building, Capitol Square, Room 262, Richmond, Virginia.

On April 25, 1994, the Safety and Health Codes Board adopted an identical version of federal OSHA's Longshoring Standard for Hazard Communication, 29 CFR 1918.90, as published in the Federal Register, Vol. 59, No. 27, pp. 6169-6184, Wednesday, February 9, 1994. The standard as adopted is not set out.

When the regulations, as set forth in the Longshoring Standard for Hazard Communication, § 1918.90, are applied to the Commissioner of the Department of Labor and

Industry or to Virginia employers, the following federal terms shall be considered to read as follows:

<u>Federal Terms</u>	<u>VOSH Equivalent</u>
29 CFR	VOSH Standard
Assistant Secretary	Commissioner of Labor and Industry
March 11, 1994	July 1, 1994

VA.R. Doc. No. R94-939; Filed May 2, 1994, 10:55 a.m.



COMMONWEALTH of VIRGINIA

JOAN W. SMITH
REGISTRAR OF REGULATIONS

VIRGINIA CODE COMMISSION
General Assembly Building

110 CAPITOL STREET
RICHMOND, VIRGINIA 23219
(804) 786-2591

May 11, 1994

Mr. Linwood Saunders, Chairman
Virginia Safety and Health Codes Board
c/o Mr. John J. Crisanti, Director
Office of Enforcement Policy
The Department of Labor and Industry
13 South Thirteenth Street
Richmond, Virginia 23219

RE: VR 425-02-174, Longshoring Standard for
Hazard Communication, 1918.90

Dear Mr. Saunders:

This will acknowledge receipt of the above-referenced regulations from the Department of Labor and Industry.

As required by § 9-6.14:4.1 C.4.(c) of the Code of Virginia, I have determined that these regulations are exempt from the operation of Article 2 of the Administrative Process Act, since they do not differ materially from those required by federal law.

Sincerely,

Joan W. Smith
Registrar of Regulations

/s/ JWS:jbc

Final Regulations

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (BOARD OF)

REGISTRAR'S NOTICE: The regulations are exempt from the Administrative Process Act in accordance with § 9-6.14:4.1 C 4(c) of the Code of Virginia, which excludes regulations that are necessary to meet the requirements of federal law or regulations, provided such regulations do not differ materially from those required by federal law or regulation, and in accordance with § 9-6.14:4.1 C 4(a), which excludes regulations that are necessary to conform to changes in Virginia statutory law or the appropriation act where no agency discretion is involved. The Department of Medical Assistance Services will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulations: State Plan for Medical Assistance Relating to OBRA '93 Medical Child Support.

VR 460-01-69. Third Party Liability (§ 4.22 (a) and (b))

VR 460-01-69.1. Third Party Liability (§ 4.22(c), (d), and (e)).

VR 460-01-70. Third Party Liability (§ 4.22(f), (g), and (h)).

Statutory Authority: § 32.1-325 of the Code of Virginia.

Effective Date: July 1, 1994.

Summary:

The purpose of this action is to amend the Plan for Medical Assistance concerning medical child support due to action taken by the Congress in OBRA '93 § 13623 and by the General Assembly in laws enacted during the 1994 session. This action is intended to provide more health insurance coverage for children, whenever the custodial parent or an absent parent has health insurance coverage available through an employer, to reduce the financial burden on the Title XIX medical assistance tax dollars.

The section of the State Plan affected by this action contains preprint pages 69, 69a, and 70 (VR 460-01-69, VR 460-01-69.1, and VR 460-01-70.)

The following measures will bring the State Plan into conformity with the provisions of federal law as enacted in §§ 13622 and 5188 of the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) and state law (HB 1057 and HB 1305) enacted during the 1994 session of the General Assembly:

1. Prohibit insurers from taking Medicaid status into account when enrolling an individual or in making benefit payments;

2. Provide that the Commonwealth has a right to third party payments to the extent it has paid for benefits or services for an individual covered by insurance;

3. Prohibit an insurer from denying enrollment of a child who has been born out of wedlock, has not been claimed on the parent's federal income tax return, or does not reside with the parents or in the insurer's service area;

4. Permit an employer to withhold from an employee's compensation the employer's share of premiums for health coverage;

5. Prohibit an insurer from imposing requirements on a state agency administering Medicaid which has been assigned the rights of an individual eligible for medical assistance different from an agent or assignee;

6. Permit the state agency to garnish wages, salary or other employment income of, and withhold state tax refunds to any person who is required by court or administrative order to provide insurance coverage to a child eligible for medical assistance. The parent must have received payment from a third party for the cost of services, but has not used such payment to reimburse the other parent or the provider of services; and

7. Require group health plans to treat children placed in a participant's home or adoption the same as natural children and not restrict coverage solely because of the child's preexisting condition.

Because of various loopholes in prior laws and regulations, insurers and other liable third parties were able to escape their liability to provide health care coverage and medical care to Medicaid and children of absent parents.

Because these regulations merely reflect federal and state laws, the agency projects no negative issues involved in implementing this regulatory change. The primary advantages to this action are to improve the collection of recoveries from liable third parties under the Medicaid last payor status, improve insurance coverage for Medicaid and children who are receiving child support from absent parents, reduce the financial burden on custodial parents for providing care to these children, and improve the payment process to care providers. There are no disadvantages to the public or the state from this legislation and rulemaking. There will be an impact on insurers, employers and absent parents which may not be perceived as positive from their particular perspective, but the overall legislation is good public policy.

This regulation, as did the legislation that preceded it, affects a number of different groups and constituencies. There will be a positive impact on the Medicaid agency and the Commonwealth because more Medicaid children will be covered by insurance and collection enforcement will be improved. There will be a positive impact on custodial parents because

of the improved Medicaid coverage.

The regulation places new burdens on insurers and employers which may not be received positively. It also puts new responsibilities on absent parents. The legislation and these companion regulations should help assist providers in receiving reimbursement for services provided to these children.

Although there will be a positive fiscal impact to Medicaid because of improved insurance coverage, the overall impact to the program will be relatively small. This is because the average annual expenditure for services is small for children under the age of 21 compared to other groups. During 1993 the average annual expenditure for a child under 21 was approximately \$900 as compared to disabled adults at \$6,405, and the aged at \$6,297. In addition, these changes will affect only a small portion of our eligible children.

Based upon enactment of HB 1057 and on the percentage of individuals covered by ERISA plans, general fund recoveries could increase by approximately \$310,000 in fiscal year 1995 and approximately \$420,000 in fiscal year 1996. Once savings begin, they will be reflected in the agency forecast.

VR 460-01-69. Third Party Liability (§ 4.22(a) and (b)).

§ 4.22. Third Party Liability.

Citation: 42 CFR 433.137

(a) The Medicaid agency meets all requirements of:

- (1) 42 CFR 433.138 and 433.139.
- (2) 42 CFR 433.145 through 433.148.
- (3) 42 CFR 433.151 through 433.154.
- (4) Sections 1902(a)(25)(H) and (I) of the Act.

Citation: 1902(a)(25)(H) and (I) of the Act; 42 CFR 433.138(f)

(b) Attachment 4.22 - A

- (1) Specifies the frequency with which the data exchanges required in § 433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in § 433.138(e) are conducted;

Citation: 42 CFR 433.138(g)(1)(ii) and (2)(ii)

- (2) Describes the methods the agency uses for meeting the follow-up requirements contained in § 433.138(g)(1)(i) and (g)(2)(i);

Citation: 42 CFR 433.138(g)(3)(i) and (iii)

- (3) Describes the methods the agency uses for following up on information obtained through the state motor vehicle accident report file data exchange required under § 433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow up that identifies legally liable third party resources; and

Citation: 42 CFR 433.138(g)(4)(i) through (iii)

- (4) Describes the methods the agency uses for following up on paid claims identified under § 433.13(a) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow up that identifies legally liable third party resources.

VR 460-01-69.1. Third Party Liability (§ 4.22(c), (d), and (e)).

§ 4.22 (continued)

Citation: 42 CFR 433.139(b)(3)(ii)(A)

(c) Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the state IV-D agency.

(d) Attachment 4.22-B specifies the following:

Citation: 42 CFR 433.139(b)(3)(ii)(C)

- (1) The method used in determining a provider's compliance with the third party billing requirements at § 433.139(b)(3)(ii)(C).

Citation: 42 CFR 433.139(f)(2)

- (2) The threshold amount or other guideline used in determining whether to seek recovery or reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.

Citation: 42 CFR 433.139(f)(3)

- (3) The dollar amount or time period the state uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.

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Citation: 42 CFR 447.20

(e) The Medicaid agency ensures that the provider furnishing a service for a service for which a third party is liable follows the restrictions specified in 42 CFR 442.20.

VR 460-01-70. Third Party Liability (§ 4.22(f), (g), and (h)).

§ 4.22 (continued)

Citation: 42 CFR 433.151(a) ; 50 FR 46652

(f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the state as a condition of eligibility for medical assistance with at least one of the following: (Check as appropriate.)

- ☒ State title IV-D agency. The requirements of 42 CFR 433.152(b) are met.
- ☐ Other appropriate state agency(s)
- ☐ Other appropriate agency(s) of another state
- ☐ Courts and law-enforcement officials.

Citation: 42 CFR 433.151(b); 50 FR 46652 1902(a)(60) of the Act

(g) The Medicaid agency meets the requirements of 42 CFR 433.153 and 433.154 for making incentive payments and for distributing third party collections.

Incentive payments under § 433.153 are not applicable to Virginia Medicaid since the state will be making collections itself (refer to State Medicaid Manual Part 3 - Eligibility (December 1985 § 3906 B)

(g) The Medicaid agency assures that the state has in effect the laws relating to medical child support under § 1908 of the Act.

Citation: 1906 of the Act

(h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.

- ☐ The Secretary's method as provided in the State Medicaid Manual, § 3910.
- ☒ The state provides methods for determining cost effectiveness on Attachment 4.22-C (VR 460-02-4.2230).

V.A.R. Doc. No. R94-949; Filed May 5, 1994, 11:21 a.m.



COMMONWEALTH of VIRGINIA

VIRGINIA CODE COMMISSION
General Assembly Building

910 CAPITOL STREET
RICHMOND, VIRGINIA 23219
(804) 780-3591

May 11, 1994

Mr. Bruce Kozlowski, Commissioner
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

RE: VR 460-01-69; 460-01-69.1; 460-01-70 - Third Party Liability

Dear Mr. Kozlowski:

This will acknowledge receipt of the above-referenced regulations from the Department of Medical Assistance Services.

As required by 5 9-6.14:4.1 C.4.(c). of the Code of Virginia, I have determined that these regulations are exempt from the operation of Article 2 of the Administrative Process Act, since they do not differ materially from those required by federal law. However, this determination is premised on the assumption that both the Attorney General's Office and HCFA approve the content as complying with the relevant law.

Sincerely,

Carol Z. Spence

WTS: jll

* * * * *

REGISTRAR'S NOTICE: The amendments to the following regulation are exempt from the Administrative Process Act in accordance with § 9-6.14:4.1 C 4(c) of the Code of Virginia, which excludes regulations that are necessary to meet the requirements of federal law or regulations, provided such regulations do not differ materially from those required by federal law or regulation, and in accordance with § 9-6.14:4.1 C 4(a), which excludes regulations which are necessary to conform to changes in Virginia statutory law or the appropriation act where no agency discretion is involved. The Department of Medical Assistance Services will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: State Plan for Medical Assistance Relating to Rebasing State-Owned University Teaching Hospitals; 1994 Disproportionate Share Hospital Payments.

VR 460-02-4.1910. Methods and Standards for Establishing Payment Rates—Inpatient Hospital Care.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Effective Date: July 1, 1994.

Summary:

The purpose of this action is to amend the Plan for Medical Assistance concerning rebasing of state-owned university teaching hospitals due to action taken by the 1994 General Assembly in the Appropriations Act Item 396G. This action also implements the requirements of the Omnibus Budget Reconciliation Act (OBRA) of 1993, § 13621, regarding payments to disproportionate share hospitals.

The section of the State Plan affected by this action is Attachment 4.19A to the State Plan.

Rebasing State-Owned University Teaching Hospitals

This regulation will increase reimbursement to state-owned university teaching hospitals. It is resulting from a mandate to DMAS in the Appropriations Act Item 396G.

Effective July 1, 1988, the State Plan was amended to set a separate ceiling for the two state-owned university teaching hospitals. The change addressed a disparity in the prior reimbursement system which grouped the two state-owned university teaching hospitals with hospitals of similar bed size and geographic area for the purpose of establishing a reimbursement ceiling for inpatient operating costs. Because of extensive medical educational activities, state-owned university teaching hospitals incurred higher operating costs and provided a higher percentage of care to Medicaid patients (18% of the

total Medicaid days) than privately operated facilities. As a result, state-owned university teaching hospitals incurred a greater disparity between Medicaid reimbursement and their actual operating costs.

Creation of a separate group ceiling for the state-owned university teaching hospitals eliminated the previous disparity and allowed them to recover more of their unique costs. Existing policy is based on a base year of 1988 for rate setting. The current regulatory action will result in the use of 1993 as a basis for rate setting. This will ensure that more current data is used to determine the ceiling.

The advantage of the regulatory action is a more generous Medicaid reimbursement to the state-owned university teaching hospitals. There are no known disadvantages. The agency projects no negative issues involved in implementing this regulatory change.

The two state-owned university teaching hospitals, University of Virginia and Medical College of Virginia, are affected by this regulatory action. No recipients are affected. The budgetary impact is projected to be an increase of \$17,400,000 (\$8,700,000 General Fund and \$8,700,000 Nongeneral Fund) per year for FY 1995 and FY 1996. This funding is provided for in HB 30 as referred to the Governor.

1994 Disproportionate Share Hospitals

Congress enacted § 4112 of OBRA 1987 to establish minimum uniform requirements for the states to follow in establishing methods for defining disproportionate share hospitals and determining payment adjustments. Effective November 9, 1989, the State Plan was amended to comply with the federal regulation.

Currently, payments to disproportionate share hospitals are made in accordance with the State Plan and there is no ceiling requirement contained in the State Plan. OBRA 1993, § 13621, requires that a limitation calculated as set forth in 42 U.S.C. 1396r-4(g) be applied to payments to disproportionate share hospitals. This State Plan amendment will implement the federal legislative requirements regarding limitations on payments to disproportionate share hospitals.

The limit imposed by OBRA 1993 is effective July 1, 1994, for public hospitals and July 1, 1995, for private hospitals. It provides that disproportionate share hospital payment adjustments can be no more than the costs of providing inpatient and outpatient services to Medicaid and uninsured patients, less payments received from Medicaid (other than disproportionate share hospital payment adjustments) and uninsured patients. (Revenues also do not include grants from government agencies.)

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For public hospitals with high disproportionate share, there is a one-year transition period during which they may receive disproportionate share hospital payments in an amount up to 200% of costs of providing services (again, net of nondisproportionate share hospital Medicaid revenues), so long as the Governor certifies to the Secretary that the payments in excess of 100% of the costs are used for health services. (High disproportionate share means that the hospital meets a high volume test or has a Medicaid utilization rate of at least one standard deviation above the mean for the state.)

The advantage of the regulatory action is to assure compliance with federal law, preventing the state from losing its federal financial participation. The disadvantage is that the amendment may reduce payments to some private disproportionate share hospitals and will reduce payments to some public disproportionate share hospitals.

It is estimated that this action will reduce payments to state mental health and mental retardation hospitals by \$9.5 million (the '94-96 biennium budget for the Department of Mental Health, Mental Retardation and Substance Abuse Services reflects this reduction) and to Lake Taylor Hospital by \$1.9 million in SFY 1995. Lake Taylor Hospital has been informed of the impact of this federally mandated change. Approximately the same amounts would apply in SFY 1996. The \$9.5 million change is accounted for in the DMAS current budget. The \$9.5 million will be reflected in the forecast for the upcoming budget cycle.

VR 460-02-4.1910. Methods and Standards for Establishing Payment Rates – Inpatient Hospital Care.

The state agency will pay the reasonable cost of inpatient hospital services provided under the Plan. In reimbursing hospitals for the cost of inpatient hospital services provided to recipients of medical assistance.

I. For each hospital also participating in the Health Insurance for the Aged Program under Title XVIII of the Social Security Act, the state agency will apply the same standards, cost reporting period, cost reimbursement principles, and method of cost apportionment currently used in computing reimbursement to such a hospital under Title XVIII of the Act, except that the inpatient routine services costs for medical assistance recipients will be determined subsequent to the application of the Title XVIII method of apportionment, and the calculation will exclude the applicable Title XVIII inpatient routing service charges or patient days as well as Title XVIII inpatient routine service cost.

II. For each hospital not participating in the Program under Title XVIII of the Act, the state agency will apply the standards and principles described in 42 CFR 447.250 and either (a) one of the available alternative cost

apportionment methods in 42 CFR 447.250, or (b) the "Gross RCCAC method" of cost apportionment applied as follows: For a reporting period, the total allowable hospital inpatient charges; the resulting percentage is applied to the bill of each inpatient under the Medical Assistance Program.

III. For either participating or nonparticipating facilities, the Medical Assistance Program will pay no more in the aggregate for inpatient hospital services than the amount it is estimated would be paid for the services under the Medicare principles of reimbursement, as set forth in 42 CFR 447.253(b)(2), and/or lesser of reasonable cost or customary charges in 42 CFR 447.250.

IV. The state agency will apply the standards and principles as described in the state's reimbursement plan approved by the Secretary, HHS on a demonstration or experimental basis for the payment of reasonable costs by methods other than those described in § II (a) and (b) above.

V. The reimbursement system for hospitals includes the following components:

(1) Hospitals were grouped by classes according to number of beds and urban versus rural. (Three groupings for rural—0 to 100 beds, 101 to 170 beds, and over 170 beds; four groupings for urban—0 to 100, 101 to 400, 401 to 600, and over 600 beds.) Groupings are similar to those used by the Health Care Financing Administration (HCFA) in determining routine cost limitations.

(2) Prospective reimbursement ceilings on allowable operating costs were established as of July 1, 1982, for each grouping. Hospitals with a fiscal year end after June 30, 1982, were subject to the new reimbursement ceilings.

The calculation of the initial group ceilings as of July 1, 1982, was based on available, allowable cost data for all hospitals in calendar year 1981. Individual hospital operating costs were advanced by a reimbursement escalator from the hospital's year end to July 1, 1982. After this advancement, the operating costs were standardized using SMSA wage indices, and a median was determined for each group. These medians were readjusted by the wage index to set an actual cost ceiling for each SMSA. Therefore, each hospital grouping has a series of ceilings representing one of each SMSA area. The wage index is based on those used by HCFA in computing its Market Basket Index for routine cost limitations.

Effective July 1, 1986, and until June 30, 1988, providers subject to the prospective payment system of reimbursement had their prospective operating cost rate and prospective operating cost ceiling computed using a new methodology. This method uses an allowance for inflation based on the percent of change

in the quarterly average of the Medical Care Index of the Chase Econometrics - Standard Forecast determined in the quarter in which the provider's new fiscal year began.

The prospective operating cost rate is based on the provider's allowable cost from the most recent filed cost report, plus the inflation percentage add-on.

The prospective operating cost ceiling is determined by using the base that was in effect for the provider's fiscal year that began between July 1, 1985, and June 1, 1986. The allowance for inflation percent of change for the quarter in which the provider's new fiscal year began is added to this base to determine the new operating cost ceiling. This new ceiling was effective for all providers on July 1, 1986. For subsequent cost reporting periods beginning on or after July 1, 1986, the last prospective operating rate ceiling determined under this new methodology will become the base for computing the next prospective year ceiling.

Effective on and after July 1, 1988, and until June 30, 1989, for providers subject to the prospective payment system, the allowance for inflation shall be based on the percent of change in the moving average of the Data Resources, Incorporated Health Care Cost HCFA-Type Hospital Market Basket determined in the quarter in which the provider's new fiscal year begins. Such providers shall have their prospective operating cost rate and prospective operating cost ceiling established in accordance with the methodology which became effective July 1, 1986. Rates and ceilings in effect July 1, 1988, for all such hospitals shall be adjusted to reflect this change.

Effective on and after July 1, 1989, for providers subject to the prospective payment system, the allowance for inflation shall be based on the percent of change in the moving average of the Health Care Cost HCFA-Type Hospital Market Basket, adjusted for Virginia (DRI-V), as developed by Data Resources, Incorporated, determined in the quarter in which the provider's new fiscal year begins. Such providers shall have their prospective operating cost rate and prospective operating cost ceiling established in accordance with the methodology which became effective July 1, 1986. Rates and ceilings in effect July 1, 1989, for all such hospitals shall be adjusted to reflect this change.

Effective on and after July 1, 1992, for providers subject to the prospective payment system, the allowance for inflation, as described above, which became effective on July 1, 1989, shall be converted to an escalation factor by adding two percentage points (200 basis points) (DRI-V+2), to the then current allowance for inflation. The escalation factor shall be applied in accordance with the current inpatient hospital reimbursement methodology in effect on June 30, 1992. On July 1, 1992, the conversion to

the new escalation factor shall be accomplished by a transition methodology which, for non-June 30 year end hospitals, applies the escalation factor to escalate their payment rates for the months between July 1, 1992, and their next fiscal year ending on or before May 31, 1993.

The new method shall still require comparison of the prospective operating cost rate to the prospective operating ceiling. The provider is allowed the lower of the two amounts subject to the lower of cost or charges principles.

(3) Subsequent to June 30, 1992, the group ceilings shall not be recalculated on allowable costs, but shall be updated by the escalator.

(4) Prospective rates for each hospital shall be based upon the hospital's allowable costs plus the escalator, or the appropriate ceilings, or charges; whichever is lower. Except to eliminate costs that are found to be unallowable, no retrospective adjustment shall be made to prospective rates.

Depreciation, capital interest, and education costs approved pursuant to PRM-15 (Sec. 400), shall be considered as pass throughs and not part of the calculation.

(5) An incentive plan shall be established whereby a hospital will be paid on a sliding scale, percentage for percentage, up to 25% of the difference between allowable operating costs and the appropriate per diem group ceiling when the operating costs are below the ceilings. The incentive shall be calculated based on the annual cost report.

The table below presents three examples under the new plan:

Group Ceiling	Hospital's Allowable Cost Per Day		Difference % of Ceiling	Sliding Scale Incentive % of Difference
	\$			\$
\$230	\$230	0	0	0
\$230	207	23.00	10%	2.30
\$230	172	57.50	25%	14.38
\$230	143	76.00	33%	19.00

(6) There shall be special consideration for exception to the median operating cost limits in those instances where extensive neonatal care is provided.

(7) Disproportionate share hospitals defined.

The following criteria shall be met before a hospital is determined to be eligible for a disproportionate share payment adjustment.

A. Criteria.

1. A Medicaid inpatient utilization rate in excess of

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8.0% for hospitals receiving Medicaid payments in the Commonwealth, or a low-income patient utilization rate exceeding 25% (as defined in the Omnibus Budget Reconciliation Act of 1987 and as amended by the Medicare Catastrophic Coverage Act of 1988); and

2. At least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

3. Subsection A 2 does not apply to a hospital:

a. At which the inpatients are predominantly individuals under 18 years of age; or

b. Which does not offer nonemergency obstetric services as of December 21, 1987.

B. Payment adjustment.

1. Hospitals which have a disproportionately higher level of Medicaid patients shall be allowed a disproportionate share payment adjustment based on the type of hospital and on the individual hospital's Medicaid utilization. There shall be two types of hospitals: (i) Type One, consisting of state-owned teaching hospitals, and (ii) Type Two, consisting of all other hospitals. The Medicaid utilization shall be determined by dividing the total number of Medicaid inpatient days by the number of inpatient days. Each hospital with a Medicaid utilization of over 8.0% shall receive a disproportionate share payment adjustment.

2. For Type One hospitals, the disproportionate share payment adjustment shall be equal to the product of (i) the hospital's Medicaid utilization in excess of 8.0%, times 11, times (ii) the lower of the prospective operating cost rate or ceiling. For Type Two hospitals, the disproportionate share payment adjustment shall be equal to the product of (i) the hospital's Medicaid utilization in excess of 8.0%, times (ii) the lower of the prospective operating cost rate or ceiling.

3. No payments made under subdivision 1 or 2 of this subsection shall exceed any applicable limitations upon such payments established by federal law or regulations.

(8) Outlier adjustments.

a. DMAS shall pay to all enrolled hospitals an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1991, involving exceptionally high costs

for individuals under one year of age.

b. DMAS shall pay to disproportionate share hospitals (as defined in V (7) above) an outlier adjustment in payment amount for medically necessary inpatient hospital services provided on or after July 1, 1991, involving exceptionally high costs for individuals under six years of age.

c. The outlier adjustment calculation.

(1) Each eligible hospital which desires to be considered for the adjustment shall submit a log which contains the information necessary to compute the mean of its Medicaid per diem operating cost of treating individuals identified in (8) a or b above. This log shall contain all Medicaid claims for such individuals, including, but not limited to: (i) the patient's name and Medicaid identification number; (ii) dates of service; (iii) the remittance date paid; (iv) the number of covered days; and (v) total charges for the length of stay. Each hospital shall then calculate the per diem operating cost (which excludes capital and education) of treating such patients by multiplying the charge for each patient by the Medicaid operating cost-to-charge ratio determined from its annual cost report.

(2) Each eligible hospital shall calculate the mean of its Medicaid per diem operating cost of treating individuals identified in (8) a or b above. Any hospital which qualifies for the extensive neonatal care provision (as governed by V (6) above) shall calculate a separate mean for the cost of providing extensive neonatal care to individuals identified in (8) a or b above.

(3) Each eligible hospital shall calculate its threshold for payment of the adjustment, at a level equal to two and one-half standard deviations above the mean or means calculated in (8) c (2) above.

(4) DMAS shall pay as an outlier adjustment to each eligible hospital all per diem operating costs which exceed the applicable threshold or thresholds for that hospital.

d. Pursuant to § 1 of Supplement 1 to Attachment 3.1 A & B, there is no limit on length of time for medically necessary stays for individuals under six years of age. This section provides that consistent with the EPSDT program referred to in 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination. Medical documentation justifying admission and the continued length of stay must be attached to or

written on the invoice for review by medical staff to determine medical necessity. Medically unjustified days in such admissions will be denied.

VI. In accordance with Title 42 §§ 447.250 through 447.272 of the Code of Federal Regulations which implements § 1902(a)(13)(A) of the Social Security Act, the Department of Medical Assistance Services ("DMAS") establishes payment rates for services that are reasonable and adequate to meet the costs that shall be incurred by efficiently and economically operated facilities to provide services in conformity with state and federal laws, regulations, and quality and safety standards. To establish these rates Virginia uses the Medicare principles of cost reimbursement in determining the allowable costs for Virginia's prospective payment system. Allowable costs will be determined from the filing of a uniform cost report by participating providers. The cost reports are due not later than 90 days after the provider's fiscal year end. If a complete cost report is not received within 90 days after the end of the provider's fiscal year, the Program shall take action in accordance with its policies to assure that an overpayment is not being made. The cost report will be judged complete when DMAS has all of the following:

1. Completed cost reporting form(s) provided by DMAS, with signed certification(s);
2. The provider's trial balance showing adjusting journal entries;
3. The provider's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), a statement of changes in financial position, and footnotes to the financial statements;
4. Schedules which reconcile financial statements and trial balance to expenses claimed in the cost report;
5. Home office cost report, if applicable; and
6. Such other analytical information or supporting documents requested by DMAS when the cost reporting forms are sent to the provider.

Although utilizing the cost apportionment and cost finding methods of the Medicare Program, Virginia does not adopt the prospective payment system of the Medicare Program enacted October 1, 1983.

VII. Revaluation of assets.

A. Effective October 1, 1984, the valuation of an asset of a hospital or long-term care facility which has undergone a change of ownership on or after July 18, 1984, shall be the lesser of the allowable acquisition cost to the owner of record as of July 18, 1984, or the acquisition cost to the new owner.

B. In the case of an asset not in existence as of July 18,

1984, the valuation of an asset of a hospital or long-term care facility shall be the lesser of the first owner of record, or the acquisition cost to the new owner.

C. In establishing an appropriate allowance for depreciation, interest on capital indebtedness, and return on equity (if applicable prior to July 1, 1986) the base to be used for such computations shall be limited to A or B above.

D. Costs (including legal fees, accounting and administrative costs, travel costs, and feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) shall be reimbursable only to the extent that they have not been previously reimbursed by Medicaid.

E. The recapture of depreciation up to the full value of the asset is required.

F. Rental charges in sale and leaseback agreements shall be restricted to the depreciation, mortgage interest and (if applicable prior to July 1, 1986) return on equity based on cost of ownership as determined in accordance with A and B above.

VIII. Refund of overpayments.

A. Lump sum payment.

When the provider files a cost report indicating that an overpayment has occurred, full refund shall be remitted with the cost report. In cases where DMAS discovers an overpayment during desk review, field audit, or final settlement, DMAS shall promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken even though the provider disputes in whole or in part DMAS's determination of the overpayment.

B. Offset.

If the provider has been overpaid for a particular fiscal year and has been underpaid for another fiscal year, the underpayment shall be offset against the overpayment. So long as the provider has an overpayment balance, any underpayments discovered by subsequent review or audit shall also be used to reduce the remaining amount of the overpayment.

C. Payment schedule.

If the provider cannot refund the total amount of the overpayment (i) at the time it files a cost report indicating that an overpayment has occurred, the provider shall request an extended repayment schedule at the time of filing, or (ii) within 30 days after receiving the DMAS demand letter, the provider shall promptly request an extended repayment schedule.

DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, if a

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provider demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of the Department of Medical Assistance Services ("the director") may approve a repayment schedule of up to 36 months.

A provider shall have no more than one extended repayment schedule in place at one time. If an audit later uncovers an additional overpayment, the full amount shall be repaid within 30 days unless the provider submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amount.

If, during the time an extended repayment schedule is in effect, the provider withdraws from the Program or fails to file a cost report in a timely manner, the outstanding balance shall become immediately due and payable.

When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered by the reduction of interim payments to the provider or by lump sum payments.

D. Extension request documentation.

In the request for an extended repayment schedule, the provider shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the provider written notification of the approved repayment schedule, which shall be effective retroactive to the date the provider submitted the proposal.

E. Interest charge on extended repayment.

Once an initial determination of overpayment has been made, DMAS shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the initial determination of overpayment. If an appeal follows, interest shall be waived during the period of administrative appeal of an initial determination of overpayment.

Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 of the Code of Virginia from the date the director's determination becomes final.

The director's determination shall be deemed to be final on (i) the due date of any cost report filed by the provider indicating that an overpayment has occurred, or (ii) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (iii) the issue date of any administrative decision issued by DMAS after an informal factfinding conference, if the provider does not file an appeal, or (iv) the issue date of any administrative decision signed by the director, regardless of whether a judicial appeal follows. In any event, interest

shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the provider shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the provider paid to DMAS.

IX. Effective October 1, 1986, hospitals that have obtained Medicare certification as inpatient rehabilitation hospitals or rehabilitation units in acute care hospitals, which are exempted from the Medicare Prospective Payment System (DRG), shall be reimbursed in accordance with the current Medicaid Prospective Payment System as described in the preceding sections I, II, III, IV, V, VI, VII, VIII and excluding V(6). Additionally, rehabilitation hospitals and rehabilitation units of acute care hospitals which are exempt from the Medicare Prospective Payment System will be required to maintain separate cost accounting records, and to file separate cost reports annually utilizing the applicable Medicare cost reporting forms (HCFA 2552 series) and the Medicaid forms (MAP-783 series).

A new facility shall have an interim rate determined using a pro forma cost report or detailed budget prepared by the provider and accepted by the DMAS, which represents its anticipated allowable cost for the first cost reporting period of participation. For the first cost reporting period, the provider will be held to the lesser of its actual operating cost or its peer group ceiling. Subsequent rates will be determined in accordance with the current Medicaid Prospective Payment System as noted in the preceding paragraph of IX.

X. Item 398 D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

XI. State-owned university teaching hospitals.

A. Pursuant to Item 389 E4 of the 1988 Appropriation Act (as amended), effective July 1, 1988, a separate group ceiling for allowable operating costs shall be established for state-owned university teaching hospitals.

B. Effective July 1, 1994, the separate group ceiling for allowable operating costs for state-owned university teaching hospitals shall be calculated using cost report and other applicable data pertaining to facility fiscal year ending June 30, 1993.

XII. Nonenrolled providers.

A. Hospitals that are not enrolled as providers with the Department of Medical Assistance Services (DMAS) which submit claims shall be paid based on the lesser of:

1. The DMAS average reimbursable inpatient cost-to-charge ratio, updated annually on September 30

of each year based on the most recent settled cost report, for enrolled hospitals less 5.0%. (The 5.0% is for the cost of the additional manual processing of the claims.)

2. The DMAS average per diem, updated annually on September 30 of each year based on the most recent settled cost report, of enrolled hospitals excluding the state-owned teaching hospitals and disproportionate share adjustments.

B. Hospitals that are not enrolled shall submit claims using the required DMAS invoice formats. Such claims must be submitted within 12 months from date of services. A hospital is determined to regularly treat Virginia Medicaid recipients and shall be required by DMAS to enroll if it provides more than 500 days of care to Virginia Medicaid recipients during the hospitals' financial fiscal year. A hospital which is required by DMAS to enroll shall be reimbursed in accordance with the current Medicaid Prospective Payment System as described in the preceding Sections I, II, III, IV, V, VI, VII, VIII, IX, and X. The hospital shall be placed in one of the DMAS peer groupings which most nearly reflects its licensed bed size and location (Section V.(1) above). These hospitals shall be required to maintain separate cost accounting records, and to file separate cost reports annually, utilizing the applicable Medicare cost reporting forms, (HCFA 2552 Series) and the Medicaid forms (MAP-783 Series).

C. A newly enrolled facility shall have an interim rate determined using the provider's most recent filed Medicare cost report or a pro forma cost report or detailed budget prepared by the provider and accepted by DMAS, which represents its anticipated allowable cost for the first cost reporting period of participation. For the first cost reporting period, the provider shall be limited to the lesser of its actual operating costs or its peer group ceiling. Subsequent rates shall be determined in accordance with the current Medicaid Prospective Payment System as noted in § XII B.

D. Once a hospital has obtained the enrolled status, 500 days of care, the hospital must agree to become enrolled as required by DMAS to receive reimbursement. This status shall continue during the entire term of the provider's current Medicare certification and subsequent recertification or until mutually terminated with 30 days written notice by either party. The provider must maintain this enrolled status to receive reimbursement. If an enrolled provider elects to terminate the enrolled agreement, the nonenrolled reimbursement status will not be available to the hospital for future reimbursement, except for emergency care.

E. Prior approval must be received from the DMAS Health Services Review Division when a referral has been made for treatment to be received from a nonenrolled acute care facility (in-state or out-of-state), except in the case of an emergency or because medical resources or supplementary resources are more readily available in

another state.

F. Nothing in this regulation is intended to preclude DMAS from reimbursing for special services, such as rehabilitation, ventilator, and transplantation, on an exception basis and reimbursing for these services on an individually, negotiated rate basis.

XIII. Payment Adjustment Fund.

A. A Payment Adjustment Fund shall be created in each of the Commonwealth's fiscal years during the period July 1, 1992, to June 30, 1996. The Payment Adjustment Fund shall consist of the Commonwealth's cumulative addition of \$5 million in general funds and its corresponding federal financial participation for reimbursement to nonstate-owned hospitals in each of the Commonwealth's fiscal years during this period. Each July 1, or as soon thereafter as is reasonably possible, the Commonwealth shall, through a single payment to each nonstate-owned hospital, equitably and fully disburse the Payment Adjustment Fund for that year.

B. In the absence of any amendment to the State Plan, Attachment 4.19A, for the Commonwealth's fiscal year after 1996, the Payment Adjustment Fund shall be continued at the level established in 1996 and shall be disbursed in accordance with the methodology described below.

C. The Payment Adjustment Funds shall be disbursed in accordance with the following methodology:

1. Identify each nonstate-owned hospital provider (acute, neonatal and rehabilitation) receiving payment based upon its peer group operating ceiling in May of each year.
2. For each such hospital identified in subdivision 1, identify its Medicaid paid days for the 12 months ending each May 31.
3. Multiply each such hospital's days under subdivision 2 by such hospital's May individual peer group ceiling (i.e., disregarding such hospital's actual fiscal year end ceiling) as adjusted by its then current disproportionate share factor.
4. Sum all hospital amounts determined in subdivision 3.
5. For each such hospital, divide its amount determined in subdivision 3 by the total of such amounts determined in subdivision 4. This then becomes the hospital adjustment factor ("HAF") for each such hospital.
6. Multiply each such hospital's HAF times the amount of the Payment Adjustment Fund ("PAF") to determine its potential PAF share.

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7. Determine the unreimbursed Medicaid allowable operating cost per day for each such hospital in subdivision 1 for the most recent fiscal year on file at DMAS as of May 31, inflate such costs by DRI-V+2 from the midpoint of such cost report to May 31 and multiply such inflated costs per day by the days identified for that hospital in subdivision 2, creating the "unreimbursed amount."

8. Compare each such hospital's potential PAF share to its unreimbursed amount.

9. Allocate to all hospitals, where the potential PAF share exceeds the unreimbursed amount, such hospital's unreimbursed amount as its actual PAF share.

10. If the PAF is not exhausted, for those hospitals with an unreimbursed amount balance, recalculate a new HAF for each such hospital by dividing the hospital's HAF by the total of the HAFs for all hospitals with an unreimbursed amount balance.

11. Recompute each hospital's new potential share of the undisbursed PAF by multiplying such funds by each hospital's new HAF.

12. Compare each hospital's new potential PAF share to its unreimbursed amount. If the unreimbursed amounts exceed the PAF shares at all hospitals, each hospital's new PAF share becomes its actual PAF share. If some hospitals' unreimbursed amounts are less than the new potential PAF shares, allocate to such hospitals their unreimbursed amount as their actual PAF share. Then, for those hospitals with an unreimbursed amount balance, repeat steps 10, 11 and 12 until each hospital's actual PAF share is determined and the PAF is exhausted.

13. The annual payment to be made to each nonstate-owned hospital from the PAF shall be equal to their actual PAF share as determined and allocated above. Each hospital's actual PAF share payment shall be made on July 1, or as soon thereafter as is reasonably feasible.

NOTICE: The forms used in administering the State Plan for Medical Assistance Relating to Rebasing State-Owned University Teaching Hospitals are not being published due to the large number; however, the name of each form is listed below. The forms are available for public inspection at the Department of Medical Assistance Services, 600 East Broad Street, Richmond, Virginia, or at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Room 262, Richmond, Virginia.

Analysis of Interim Payments - Title XIX.

Computation of Title XIX Ratio of Cost to Charges.

Computation of Title XIX Ancillary Service Costs.

Computation of Outpatient Capital Reduction.

Computation of Title XIX Outpatient Costs.

Computation of Title XIX Program Charges.

Computation of Title XIX Reimbursement Settlement.

Determination of Plant Costs.

Determination of Education Costs.

Computation of Medicaid Plant and Education Cost (pass-throughs).

Computation of Net Medicaid Inpatient Operating Cost Adjustment.

Calculation of Inpatient Profit Incentive and Disproportionate Share Adjustment.

Disproportionate Share Reporting Form.

VA.R. Doc. No. R94-950; Filed May 5, 1994, 11:20 a.m.



COMMONWEALTH of VIRGINIA

JOAN W. SMITH
REGISTRAR OF REGULATIONS

VIRGINIA CODE COMMISSION
General Assembly Building

310 CAPITOL STREET
RICHMOND, VIRGINIA 23219
(804) 786-2551

May 11, 1994

Mr. Bruce Kozlowski, Commissioner
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

RE: VR 460-02-4.1910 - Methods and Standard for Establishing Payment Rates -- Inpatient Hospital Care

Dear Mr. Kozlowski:

This will acknowledge receipt of the above-referenced regulations from the Department of Medical Assistance Services.

As required by § 9-6.14:4.1 C.4.(c). of the Code of Virginia, I have determined that the disproportionate share changes in these regulations are exempt from the operation of Article 2 of the Administrative Process Act, since they do not differ materially from those required by federal law. However, this determination is premised on the assumption that both the Attorney General's Office and HCA approve the content as complying with the relevant law.

Sincerely,

JOAN W. SMITH
REGISTRAR OF REGULATIONS

WJS:jbc

REGISTRAR'S NOTICE: The amendments to the following regulation are exempt from the Administrative Process Act in accordance with § 9-6.14:4.1 C 4 (c) of the Code of Virginia, which excludes regulations that are necessary to meet the requirements of federal law or regulations, provided such regulations do not differ materially from those required by federal law or regulation, and in accordance with § 9-6.14:4.1 C 3, which excludes regulations which consist only of changes in style or form or corrections of technical errors. The Department of Medical Assistance Services will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: State Plan for Medical Assistance Relating to 1994 Federal Poverty Income Levels.
VR 460-03-02.6101:1. Income Eligibility Levels.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Effective Date: June 30, 1994.

Summary:

The purpose of this Plan amending action is to make several technical corrections and to make permanent the existing emergency regulation by incorporating into the Plan the 1994 Federal Poverty Income Guidelines. The section of the State Plan which is affected by this action is Income Eligibility Levels, Attachment 2.6 A, Supplement 1 (VR 460-03-2.6101:1).

This amendment incorporates into the Plan the 1994 Federal Poverty Income Guidelines, as published by the U.S. Department of Health and Human Services (DHHS) in the February 10, 1994, Federal Register.

The Federal Register notice provided updated guidelines which are effective on the date of the Register publication. Sections 1902(l), 1902(l)(1)(D), 1902(m), and 1905(s) of the Social Security Act require states to base Medicaid eligibility on percentages of the Federal Poverty Income Guidelines for certain categories of eligible individuals. Each year when the annual Federal Poverty Income Guidelines are published, states must revise the financial eligibility income standards for the affected categories by incorporating the new income levels into the State Plan. Because the Federal Poverty Income Guidelines become effective the date they are published in the Federal Register, adoption of emergency regulations was necessary. This regulatory package supersedes those emergency regulations.

In addition, several technical corrections are being made. Section B 3 being deleted regarding children between 1 and 6 repeats the language in section A 3. Section B 3 was inadvertently retained during recent changes to the format of the regulation by HCFA, so

it is being deleted to conform to HCFA's format. Section B 2 being added regarding children between ages 6 and 8 was inadvertently omitted during recent changes to the format of the regulation. This group of children is covered elsewhere, so this section does not apply to DMAS. It is being included to conform with the federal format.

VR 460-03-2.6101:1. Income Eligibility Levels.

A. Mandatory categorically needy.

1. AFDC-related groups other than poverty level pregnant women and infants.

Maximum Payment		
Family Size	Need Standard	Payment Standard
Amounts		

See Table 1

See Table 2

STANDARDS OF ASSISTANCE

GROUP I

Size of Assistance Unit	Table 1 (100%)	Table 2 (90%)
1	\$ 146	\$ 131
2	229	207
3	295	265
4	358	322
5	422	380
6	473	427
7	535	482
8	602	541
9	657	591
10	718	647
Each person above 10	61	56

MAXIMUM REIMBURSABLE PAYMENT \$403

GROUP II

Size of Assistance Unit	Table 1 (100%)	Table 2 (90%)
1	\$ 174	\$ 157
2	257	231
3	322	291
4	386	347
5	457	410
6	509	458
7	570	512
8	636	572
9	692	623
10	754	678
Each person above 10	61	56

MAXIMUM REIMBURSABLE PAYMENT \$435

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Size of Assistance Unit	GROUP III	
	Table 1 (100%)	Table 2 (90%)
1	\$ 243	\$ 220
2	327	294
3	393	354
4	457	410
5	542	488
6	593	534
7	655	590
8	721	650
9	779	701
10	838	755
Each person above 10	61	56

MAXIMUM REIMBURSABLE PAYMENT \$518

2. Pregnant women and infants under 1902(a)(10)(i)(IV) of the Act:

Effective April 1, 1990, based on the following percentage of the official federal income poverty level

☒ 133% ☐% (no more than 185%)
(specify)

Family Size	Income Level
1	\$ 9,789
2	\$13,087
3	\$16,386
4	\$19,684
5	\$22,982

3. Children under § 1902(a)(10)(i)(VI) of the Act (children who have attained age 1 but have not attained age 6), the income eligibility level is 133% of the federal poverty level (as revised annually in the Federal Register) for the size family involved.

4. For children under § 1902(a)(10)(i)(VII) of the Act (children who were born after September 30, 1983, and have attained age 6 but have not attained age 19), the income eligibility level is 100% of the federal poverty level (as revised annually in the Federal Register) for the size family involved.

B. Optional categorically needy groups with income related to federal poverty level.

1. Pregnant woman and infants. The levels for determining income eligibility for optional groups of pregnant women and infants under the provisions of §§ 1902(a)(1)(A)(ii)(IX) and 1902(l)(2) of the Act are as follows:

Based on% of the official federal income poverty level (no less than 133% and no more than 185%).

Family Size	Income Level
1	\$
2	\$
3	\$
4	\$
5	\$

2. Children between ages 6 and 19. The levels for determining income eligibility for groups of children who are born after September 30, 1973, and who have attained six years of age but are under 19 years of age under the provisions of §§ 1902(l)(2) and 1905(n)(2) of the Act are as follows:

Based on 100% (no more than 100%) of the official federal income poverty line.

Family Size	Income Level	
1	\$ 6,970	7,360
2	\$ 9,430	9,840
3	\$ 11,890	12,320
4	\$ 14,350	14,800
5	\$ 16,810	17,280
6	\$ 19,270	19,760
7	\$ 21,730	22,240
8	\$ 24,190	24,720
9	\$ 25,850	27,200
10	\$ 28,230	29,680

3. Children. Mandatory group of children under § 1902(a)(10)(i)(VI) of the Act. (Children who have attained age 1 but have not attained age 6.)

☐ Same as resource levels in the state's approved AFDC plan.

☐ Less restrictive than the AFDC levels and are as follows:

Family Size	Income Level
1	\$ 9,057
2	\$12,223
3	\$15,388
4	\$18,554
5	\$21,719
6	\$24,884
7	\$28,050
8	\$31,215
9	\$34,380
10	\$37,545

3. Children between ages 6 and 8. The levels for determining income eligibility for groups of children who are born after September 30, 1983, and who have attained 6 years of age but are under 8 years of age under the provisions of § 1902(l)(2) of the Act are

as follows:

Based on ...% (no more than 100%) of the official federal income poverty line.

Family Size	Income Level
1	\$
2	\$
3	\$
4	\$
5	\$
6	\$
7	\$
8	\$
9	\$
10	\$

N/A - Erroneous Group

4. Aged and disabled individuals. The levels for determining income eligibility for groups of aged and disabled individuals under the provisions of § 1902(m)(4) of the Act are as follows:

Based on.....% on the official federal income poverty line.

Family Size	Income Level
1	\$
2	\$
3	\$
4	\$
5	\$

If an individual receives a Title II benefit, any amount attributable to the most recent increase in the monthly insurance benefit as a result of a Title II COLA is not counted as income during a "transition period" beginning with January, when the Title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual federal poverty level.

For individuals with Title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving Title II income, the revised poverty levels are effective no later than the beginning of the month following the date of publication.

C. Qualified Medicare beneficiaries with incomes related to federal poverty level.

The levels for determining income eligibility for groups of qualified Medicare beneficiaries under the provisions of § 1905(p)(2)(A) of the Act are as follows:

1. Non-§ 1902(f) states:

a. Based on the following percentage of the official federal income poverty level:

Effective Jan. 1, 1989: ☐ 85% ☐%
(no more than 100)

Effective Jan. 1, 1990: ☐ 90% ☐%
(no more than 100)

Effective Jan. 1, 1991: 100%

Effective Jan. 1, 1992: 100%

b. Levels:

Family Size	Income Level
1	\$
2	\$

2. § 1902(f) states which as of January 1, 1987 used income standards more restrictive than SSL (VA did not apply a more restrictive income standard as of January 1, 1987.)

a. Based on the following percentage of the official federal income poverty level:

Effective Jan. 1, 1989: ☒ 85% ☐%
(no more than 100)

Effective Jan. 1, 1990: ☐ 85% ☒ 90%
(no more than 100)

Effective Jan. 1, 1991: ☐ 95% ☒ 100%
(no more than 100)

Effective Jan. 1, 1992: 100%

b. Levels:

Family Size	Income Level
1	\$ 6,810 7,360
2	\$ 9,190 9,840

D. Income levels - medically needy.

1. ☒ Applicable to all groups

☐ Applicable to all groups except those specified below. Excepted group income levels are also listed on an attached page 3.

(1) Family Size	(2) Net income level	(3) Amount by which	(4) Net income level for	(5) Amount by which Column 4 exceeds
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protected for maintenance for 12 months
 Column 2 exceeds limits specified in 42 CFR 435.1007¹
 persons living in rural areas for months
 limits specified in 42 CFR 435.1007¹

GROUP I

Counties

Accomack
 Alleghany
 Amelia
 Amherst
 Appomattox
 Bath
 Bedford
 Bland
 Botetourt
 Brunswick
 Buchanan
 Buckingham
 Campbell
 Caroline
 Carroll
 Charles City
 Charlotte
 Clarke
 Craig
 Culpeper
 Cumberland
 Dickenson
 Dinwiddie
 Essex
 Fauquier
 Floyd
 Fluvanna
 Franklin
 Frederick
 Giles
 Gloucester
 Goochland
 Grayson
 Greene
 Greenville
 Halifax
 Hanover
 Henry
 Highland
 Isle of Wight
 James City
 King George
 King and Queen
 King William
 Lancaster
 Lee
 Louisa
 Lunenburg
 Madison
 Matthews
 Mecklenburg
 Middlesex
 Nelson
 New Kent
 Northampton
 Northumberland
 Nottoway

☐ urban only

☒ urban and rural See Page 8a subdivision 2 of this subsection for required income levels.

1	\$	\$	\$	\$
2	\$	\$	\$	\$
3	\$	\$	\$	\$
4	\$	\$	\$	\$
5	\$	\$	\$	\$
6	\$	\$	\$	\$
7	\$	\$	\$	\$
8	\$	\$	\$	\$
9	\$	\$	\$	\$
10	\$	\$	\$	\$
For each additional person, add: \$				
	\$	\$	\$	\$

¹ The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

2. ☒ Applicable to all groups

☐ Applicable to:

(1) Family Size	(2) Net income level protected for maintenance	(5) Amount by which column 2 exceeds limits specified in 42 CFR 435.1007
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☐ urban only

☒ urban and rural

	Group I	Group II	Group III	
1	\$2,600	\$3,000	\$3,900	\$0
2	\$3,400	\$3,700	\$4,800	\$0
3	\$3,900	\$4,300	\$5,300	\$0
4	\$4,400	\$4,800	\$5,800	\$0
5	\$4,900	\$5,300	\$6,300	\$0
6	\$5,400	\$5,800	\$6,800	\$0
7	\$5,900	\$6,300	\$7,300	\$0
8	\$6,500	\$6,900	\$7,800	\$0
9	\$7,100	\$7,500	\$8,500	\$0
10	\$7,800	\$8,200	\$9,100	\$0
For each additional person, add				
	\$ 600	\$ 600	\$ 600	\$0

*NOTE: As authorized in § 4718 of OBRA '90.

Grouping of Localities

Orange
Page
Patrick
Pittsylvania
Powhatan
Prince Edward
Prince George
Pulaski
Rappahannock
Richmond
Rockbridge
Russell
Scott
Shenandoah
Smyth
Southampton
Spotsylvania
Stafford
Surry
Sussex
Tazewell
Washington
Westmoreland
Wise
Wythe
York

Cities

Bristol
Buena Vista
Clifton Forge
Danville
Emporia
Franklin
Galax
Norton
Poquoson
Suffolk

GROUP II

Counties

Albemarle
Augusta
Chesterfield
Henrico
Loudoun
Roanoke
Rockingham
Warren

Cities

Chesapeake
Covington
Harrisonburg
Hopewell
Lexington
Lynchburg

Martinsville
Newport News
Norfolk
Petersburg
Portsmouth
Radford
Richmond
Roanoke
Salem
Staunton
Virginia Beach
Williamsburg
Winchester

GROUP III

Counties

Arlington
Fairfax
Montgomery
Prince William

Cities

Alexandria
Charlottesville
Colonial Heights
Fairfax
Falls Church
Fredericksburg
Hampton
Manassas
Manassas Park
Waynesboro

E. Income eligibility levels—mandatory group of specified low-income Medicare beneficiaries with incomes up to federal poverty line.

The levels for determining income eligibility for groups of qualified Medicare beneficiaries under the provisions of § 1905(a)(10)(E) of the Act are as follows:

Based on 110%, and updated annually, of the official federal nonfarm income poverty line:

Size of Family Unit	Poverty Guideline	
1	\$ 7,491	\$ 8,096
2	\$10,109	\$10,824

F. Income eligibility levels—mandatory group of qualified disabled and working individuals with incomes up to federal poverty line.

The levels for determining income eligibility for groups of qualified disabled and working individuals under the provisions of § 1905(s) of the Act are as follows:

Based on 200%, and updated annually, of the official

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federal nonfarm income poverty level:

Size of Family Unit	Poverty Guideline
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1	\$14,720
2	\$19,680

VAR. Doc. No. R94-948; Filed April 29, 1994, 1:33 p.m.



COMMONWEALTH of VIRGINIA

JOAN W. SMITH
REGISTRAR OF REGULATIONS

VIRGINIA CODE COMMISSION
General Assembly Building

300 CAPITOL STREET
RICHMOND, VIRGINIA 23219
(804) 786-2591

May 11, 1994

Mr. Bruce Kozlowski, Commissioner
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

RE: VR 460-03-2.6101:1 - Income Eligibility Standards

Dear Mr. Kozlowski:

This will acknowledge receipt of the above-referenced regulations from the Department of Medical Assistance Services.

As required by § 9-6.14:4.1 C.4.(c), of the Code of Virginia, I have determined that, except for the amendments to §§ B.2 and B.3 which are exempted under the provisions of § 9-6.14:4.1 C.4 (2), these regulations are exempt from the operation of Article 2 of the Administrative Process Act, since they do not differ materially from those required by federal law. However, this determination is premised on the assumption that both the Attorney General's Office and HSPA approve the content as complying with the relevant law.

Sincerely,

Joan W. Smith
Registrar of Regulations

JWS: jbc

* * * * *

REGISTRAR'S NOTICE: This regulation is excluded from Article 2 of the Administrative Process Act in accordance with § 9-6.14:4.1 C 4(a) of the Code of Virginia, which excludes regulations that are necessary to conform to changes in Virginia statutory law or the appropriation act where no agency discretion is involved. The Department of Medical Assistance Services will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: State Plan for Medical Assistance Relating to Savings Account Exemption.
VR 460-03-2.6108.2. More Liberal Methods of Treating Resources under § 1902(r)(2) of the Act.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Effective Date: July 1, 1994.

Summary:

The purpose of this action is to amend the Plan for Medical Assistance concerning savings accounts for business incubation or operations due to action taken by the 1994 General Assembly. HB 411 expanded the conditions under which a savings account up to a value of \$5,000 can be excluded from consideration in determining eligibility for Medicaid. The purpose of this exempted \$5,000 savings account must be to establish or maintain a business operation owned by a member of the assistance unit. The business's net worth must not exceed \$5,000 in order to continue to be excluded.

The savings account exemption for business operations is intended to encourage individuals, currently receiving public assistance, to become more self-sufficient and to leave the public assistance rolls. The agency projects no negative issue involved in implementing these provisions. There are no localities which are uniquely affected by these regulations as they apply statewide.

In 1993, the General Assembly passed legislation which permitted ADC and ADC-related Medicaid recipients to have exempted savings accounts of up to \$5,000 for the costs of education or to purchase a residence. This amendment merely adds another permissible use for the savings account. DMAS anticipates that the main fiscal impact was experienced with the original savings account exemptions and does not predict significant additional fiscal impact from this change. In addition, exempting the same amount of an asset whether in a savings account or in the net worth of a nascent business will not have a fiscal impact but will help remove a significant barrier to individual initiative.

VR 460-03-2.6108.2. More Liberal Methods of Treating

Resources under § 1902(r)(2) of the Act.

☒ § 1902(f) State ☐ Non-§ 1902(f) State

§ 1. Resources to meet burial expenses.

Resources set aside to meet the burial expenses of an applicant/recipient or that individual's spouse are excluded from countable assets. In determining eligibility for benefits for medically needy individuals, disregarded from countable resources is an amount not in excess of \$2,500 for the individual and an amount not in excess of \$2,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by:

1. The face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources; and
2. The amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial expenses.

§ 2. Life rights.

Life rights to real property are not counted as a resource.

§ 3. Reasonable effort to sell.

A. For purposes of this section "current market value" is defined as the current tax assessed value. If the property is listed by a realtor, then the realtor may list it at an amount higher than the tax assessed value. In no event, however, shall the realtor's list price exceed 150% of the assessed value.

B. A reasonable effort to sell is considered to have been made:

1. As of the date the property becomes subject to a realtor's listing agreement if:
 - a. It is listed at a price at current market value, and
 - b. The listing realtor verifies that it is unlikely to sell within 90 days of listing given the particular circumstances involved (e.g., owner's fractional interest; zoning restrictions; poor topography; absence of road frontage or access; absence of improvements; clouds on title, right of way or easement; local market conditions);
2. When at least two realtors refuse to list the property. The reason for refusal must be that the property is unsaleable at current market value. Other reasons for refusal are not sufficient; or

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3. When the applicant has personally advertised his property at or below current market value for 90 days by use of a "Sale By Owner" sign located on the property and by other reasonable efforts such as newspaper advertisements, or reasonable inquiries with all adjoining landowners or other potential interested purchasers.

C. Notwithstanding the fact that the recipient made a reasonable effort to sell the property and failed to sell it, and although the recipient has become eligible, the recipient must make a continuing reasonable effort to sell by:

1. Repeatedly renewing any initial listing agreement until the property is sold. If the list price was initially higher than the tax-assessed value, the listed sales price must be reduced after 12 months to no more than 100% of the tax-assessed value.

2. In the case where at least two realtors have refused to list the property, the recipient must personally try to sell the property by efforts described in subdivision B 3 of this section, for 12 months.

3. In the case of recipient who has personally advertised his property for a year without success (the newspaper advertisements, "for sale" sign, do not have to be continuous; these efforts must be done for at least 90 days within a 12 month period), the recipient must then

a. Subject his property to a realtor's listing agreement at price or below current market value; or

b. Meet the requirements of subdivision B 2 of this section which are that the recipient must try to list the property and at least two realtors refuse to list it because it is unsaleable at current market value; other reasons for refusal to list are not sufficient.

D. If the recipient has made a continuing effort to sell the property for 12 months, then the recipient may sell the property between 75% and 100% of its tax assessed value and such sale shall not result in disqualification under the transfer of property rules. If the recipient requests to sell his property at less than 75% of assessed value, he must submit documentation from the listing realtor, or knowledgeable source if the property is not listed with a realtor, that the requested sale price is the best price the recipient can expect to receive for the property at this time. Sale at such a documented price shall not result in disqualification under the transfer of property rules. The proceeds of the sale will be counted as a resource in determining continuing eligibility.

E. Once the applicant has demonstrated that his property is unsaleable by following the procedures in subsection B of this section the property is

disregarded in determining eligibility starting the first day of the month in which the most recent application was filed, or up to three months prior to this month of application if retroactive coverage is requested and the applicant met all other eligibility requirements in the period. A recipient must continue his reasonable efforts to sell the property as required in Section C above.

§ 4. Automobiles.

Ownership of one motor vehicle does not affect eligibility. If more than one vehicle is owned, the individual's equity in the least valuable vehicle or vehicles must be counted. The value of the vehicles is the wholesale value listed in the National Automobile Dealers Official Used Car Guide (NADA) Book, Eastern Edition. In the event the vehicle is not listed, the value assessed by the locality for tax purposes may be used. The value of the additional motor vehicles is to be counted in relation to the amount of assets that could be liquidated that may be retained.

§ 5. Life, retirement, and other related types of insurance policies.

Life, retirement, and other related types of insurance policies with face values totaling \$1,500, or less on any one person 21 years old and over are not considered resources. When the face values of such policies of any one person exceeds \$1,500, the cash surrender value of the policies is counted as a resource.

§ 6. Resource exemption for Aid to Dependent Children categorically and medically needy (*the Act §§ 1902(a)(10)(A)(i)(III), (IV), (VI), (VII); §§ 1902(a)(10)(A)(ii)(VIII), (IX); § 1902(a)(10)(C)(i)(III)*).

For ADC-related cases, both categorically and medically needy, any individual or family applying for or receiving assistance may have or establish one interest-bearing savings account per assistance unit not to exceed \$5,000 at a financial institution if the applicant, applicants, recipient or recipients designate that the account is reserved for ~~the~~ *purpose of one of the following purposes: (i) paying for tuition, books, and incidental expenses at any elementary, secondary or vocational school or any college or university; or for (ii) making down payment on a primary residence ; or (iii) business incubation* . Any funds deposited in the account, and any interest earned thereon, shall be exempt when determining eligibility for medical assistance for so long as the funds and interest remain on deposit in the account. Any amounts withdrawn and used for any of the purposes stated in this section shall be exempt. *For purposes of this section, "business incubation" shall mean the initial establishment of a commercial operation which is owned by a member of the Medicaid assistance unit. The net worth of any business owned by a member of the assistance unit shall be exempt from consideration so long as the net worth of the business is less than \$5,000.*

VA.R. Doc. No. R94-976; Filed May 11, 1994, 11:45 a.m.

* * * * *

Title of Regulation: State Plan for Medical Assistance Relating to Criteria for Preadmission Screening and Continued Stay.

VR 460-03-3.1100. Narrative for the Amount, Duration and Scope of Services (Supplement 1 to Attachment 3.1 A & B).

VR 460-02-3.1300. Standards Established and Methods Used to Assure High Quality of Care (Attachment 3.1 C).

VR 460-03-3.1301. Nursing Facility and MR Criteria (Supplement 1 to Attachment 3.1 C).

VR 460-04-3.1300. Outpatient Physical Rehabilitative Services Regulations.

VR 460-04-8.10. Regulations for Long-Stay Acute Care Hospitals.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Effective Date: June 29, 1994.

Summary:

The purpose of this action is to promulgate permanent regulations to supersede the existing emergency regulations containing essentially the same policies. These regulations concern the criteria by which applicants for and recipients of long-term care services and community-based care services are evaluated for appropriate placement.

The sections of the State Plan for Medical Assistance affected by this action are: Amount, Duration, and Scope of Services Narrative (Supplement 1 to Attachment 3.1 A&B), Standards Established and Methods Used to Assure High Quality of Care (Attachment 3.1 C), Nursing Facility Criteria (Supplement 1 to Attachment 3.1 C). The non-State Plan regulations affected by this action are: Regulations for Outpatient Physical Rehabilitative Services (VR 460-04-3.1300) and Regulations for Long-Stay Acute Care Hospitals (VR 460-04-8.10).

The Department of Medical Assistance Services (DMAS) promulgated an emergency regulation for these criteria effective September 1, 1992. The agency's proposed regulations were filed March 30, 1993, with the Registrar of Regulations for publication to begin its comment period from April 20 through June 18, 1993. DMAS held four public hearings in different statewide locations and received numerous comments from individuals and organizations. These initial proposed regulations were substantially similar to the preceding emergency regulations. Commenters on those emergency regulations expressed a belief that they have resulted in the discharge of numerous nursing facility residents and the denial of various long-term care services to numerous others. Although the department's research demonstrated that there

had not been discharges from nursing facilities based on those emergency regulations, it was clear that the department's intent to clarify medical/nursing management had not been clearly communicated. Since the regulations proposed by the agency for public comment period mirrored the emergency regulations, they were opposed by the various interests groups concerned with care for the elderly and disabled. Due to the 1993 General Assembly's modifications to § 9-6.14:1 et seq. of the Administrative Process Act (APA), DMAS was required to promulgate a second set of emergency regulations. DMAS reinitiated the Article 2 process (§ 9-6.14:7.1) to conform to the new APA promulgation requirements.

Due to the significant comments DMAS received on the prior proposed regulations, the second set of emergency regulations contained revisions to the definition of medical/nursing need and revisions to the evaluation of persons seeking community-based care to avoid future nursing facility placement. HCFA allows the Commonwealth to offer home- and community-based care to persons who meet nursing facility criteria and to those whom it determines will meet nursing facility criteria in the near future except for the provision of community-based services. In the currently effective emergency regulations, DMAS established the criteria which define when an individual can be determined to be at risk of nursing facility placement in the near future as "prenursing facility criteria." These proposed regulations mirrored the current emergency regulations on which the agency has received no comments.

Nursing home preadmission screening was implemented in Virginia in 1977 to ensure that Medicaid-eligible individuals placed in nursing homes actually required nursing home care. In 1982, DMAS obtained approval for a Section 2176 home- and community-based care waiver to allow individuals who have been determined to require nursing facility services an alternative to nursing home placement. This home- and community-based care alternative to nursing home care includes personal care, respite care, and adult day health care services.

In this final regulation, DMAS has modified the definitions of functional status to make the terminology consistent between the criteria and the new assessment instrument which the Commonwealth implements effective July 1, 1994, for all publicly funded long-term care. These modifications do not impact the finding of whether the individual will be determined dependent or not for the purpose of meeting the criteria for Medicaid-funded long-term care, with one exception. The category of Medication Administration previously contained a designation of semidependency based on the frequency of administration or monitoring by professional nursing staff. Based on recommendations received during the public comment period and the need to correlate this

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activity with the category on the new assessment, the level of semidependency has been eliminated. In the final regulation, any medication administration or monitoring by professional nursing staff is considered a dependency. This has the effect of loosening the criteria somewhat rather than making it more restrictive.

Rehabilitation Services

In addition, this regulation package makes amendments to clarify and improve the consistency of the regulations as they relate to outpatient rehabilitation. DMAS is making certain nonsubstantive changes as follows:

Attachment 3.1 A & B, Supplement 1. The authorization form for extended outpatient rehabilitation services no longer requires a physician's signature. Although the physician does not sign the form, there is no change in the requirement that attached medical justification must include physician orders or a plan of care signed by the physician. Services that are noncovered home health services are described. These services are identified for provider clarification and represent current policy. Also, technical corrections have been made to bring the Plan into compliance with the 1992 Appropriations Act and previously modified policies (i.e., deleting references to the repealed Second Surgical Opinion program under § 2, Outpatient hospital services and § 5, Physicians services).

The Program's policy of covering services provided by a licensed clinical social worker under the direct supervision of a physician is extended to include such services provided under the direct supervision of a licensed clinical psychologist or a licensed psychologist clinical. This change merely makes policy consistent across different provider types.

Specialized Care

In addition, this regulation package makes amendments to clarify and improve the consistency of the regulations as they relate to specialized care services. While these changes were not addressed in the proposed regulation package, they are technical corrections which change the current requirements to minimum requirements.

Attachment 3.1-C and Attachment 3.1-C, Supplement 1. In the proposed regulation, providers are expected to count the number and length of therapy sessions for specialized care recipients. By the change herein, DMAS is eliminating the requirement that a specific number of sessions of specific duration be provided and requiring that a total amount of minutes of therapy be provided. As such, the provider may schedule the number and length of sessions which best meet each recipient's needs.

Also included is that, after the initial physician visit, subsequent visits may alternate between visits by the physician and visits by a physician assistant or nurse practitioner. This is consistent with federal guidelines for the provision of physician services in nursing facilities.

Attachment 3.1 C. The modification to outpatient rehabilitative services is also reflected in this attachment. DMAS will periodically conduct a validation survey of the assessments completed by nursing facilities to determine that services provided to the residents are medically necessary and that needed services are provided. This is changed from the requirement that assessments be conducted annually. The change to recognize the provision of psychological services by supervised licensed clinical social workers is also reflected in this Plan section.

VR 460-04-3.1300. The reference to the Rehabilitation Treatment Authorization form (DMAS-125) is deleted for outpatient rehabilitative services.

Supervision of Licensed Clinical Social Workers

VR 460-04-8.10 (Long-stay Acute Care Hospital Regulations). The same policy of providing for social workers' supervision by licensed clinical psychologists or licensed psychologists clinical is provided for in these state-only regulations.

Summary of Public Comment and Agency Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the Office of the Registrar of Regulations.

Agency Contact: Copies of the regulation may be obtained from Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219, telephone (804) 371-8850. There may be a charge for copies.

VR 460-03-3.1100. Amount, Duration and Scope of Services.

General.

The provision of the following services cannot be reimbursed except when they are ordered or prescribed, and directed or performed within the scope of the license of a practitioner of the healing arts: laboratory and x-ray services, family planning services, and home health services. Physical therapy services will be reimbursed only when prescribed by a physician.

§ 1. Inpatient hospital services other than those provided in an institution for mental diseases.

A. Medicaid inpatient hospital admissions (lengths-of-stay) are limited to the 75th percentile of PAS (Professional

Activity Study of the Commission on Professional and Hospital Activities) diagnostic/procedure limits. For admissions under 15 days that exceed the 75th percentile, the hospital must attach medical justification records to the billing invoice to be considered for additional coverage when medically justified. For all admissions that exceed 14 days up to a maximum of 21 days, the hospital must attach medical justification records to the billing invoice. (See the exception to subsection F of this section.)

B. Medicaid does not pay the medicare (Title XVIII) coinsurance for hospital care after 21 days regardless of the length-of-stay covered by the other insurance. (See exception to subsection F of this section.)

C. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment to health or life of the mother if the fetus were carried to term.

D. Reimbursement for covered hospital days is limited to one day prior to surgery, unless medically justified. Hospital claims with an admission date more than one day prior to the first surgical date will pend for review by medical staff to determine appropriate medical justification. The hospital must write on or attach the justification to the billing invoice for consideration of reimbursement for additional preoperative days. Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admissions will be denied.

E. Reimbursement will not be provided for weekend (Friday/Saturday) admissions, unless medically justified. Hospital claims with admission dates on Friday or Saturday will be pended for review by medical staff to determine appropriate medical justification for these days. The hospital must write on or attach the justification to the billing invoice for consideration of reimbursement coverage for these days. Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admissions will be denied.

F. Coverage of inpatient hospitalization will be limited to a total of 21 days for all admissions within a fixed period, which would begin with the first day inpatient hospital services are furnished to an eligible recipient and end 60 days from the day of the first admission. There may be multiple admissions during this 60-day period; however, when total days exceed 21, all subsequent claims will be reviewed. Claims which exceed 21 days within 60 days with a different diagnosis and medical justification will be paid. Any claim which has the same or similar diagnosis will be denied.

EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, payment of medical assistance services

shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination. Medical documentation justifying admission and the continued length of stay must be attached to or written on the invoice for review by medical staff to determine medical necessity. Medically unjustified days in such admissions will be denied.

G. Repealed.

H. Reimbursement will not be provided for inpatient hospitalization for those surgical and diagnostic procedures listed on the mandatory outpatient surgery list unless the inpatient stay is medically justified or meets one of the exceptions. The requirements for mandatory outpatient surgery do not apply to recipients in the retroactive eligibility period.

I. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Coverage of transplant services for all eligible persons is limited to transplants for kidneys and corneas. Kidney transplants require preauthorization. Cornea transplants do not require preauthorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. The amount of reimbursement for covered kidney transplant services is negotiable with the providers on an individual case basis. Reimbursement for covered cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in Attachment 3.1 E.

J. The department may exempt portions or all of the utilization review documentation requirements of subsections A, D, E, F as it pertains to recipients under age 21, G, or H in writing for specific hospitals from time to time as part of their ongoing hospital utilization review performance evaluation. These exemptions are based on utilization review performance and review edit criteria which determine an individual hospital's review status as specified in the hospital provider manual. In compliance with federal regulations at 42 CFR 441.200, Subparts E and F, claims for hospitalization in which sterilization, hysterectomy or abortion procedures were performed, shall be subject to medical documentation requirements.

K. Hospitals qualifying for an exemption of all documentation requirements except as described in subsection J above shall be granted "delegated review status" and shall, while the exemption remains in effect, not be required to submit medical documentation to support pended claims on a prepayment hospital utilization review basis to the extent allowed by federal or state law or regulation. The following audit conditions apply to delegated review status for hospitals:

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1. The department shall conduct periodic on-site post-payment audits of qualifying hospitals using a statistically valid sampling of paid claims for the purpose of reviewing the medical necessity of inpatient stays.

2. The hospital shall make all medical records of which medical reviews will be necessary available upon request, and shall provide an appropriate place for the department's auditors to conduct such review.

3. The qualifying hospital will immediately refund to the department in accordance with § 32.1-325.1 A and B of the Code of Virginia the full amount of any initial overpayment identified during such audit.

4. The hospital may appeal adverse medical necessity and overpayment decisions pursuant to the current administrative process for appeals of post-payment review decisions.

5. The department may, at its option, depending on the utilization review performance determined by an audit based on criteria set forth in the hospital provider manual, remove a hospital from delegated review status and reapply certain or all prepayment utilization review documentation requirements.

§ 2. Outpatient hospital and rural health clinic services.

2a. Outpatient hospital services.

A. Outpatient hospital services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that:

1. Are furnished to outpatients;
2. Except in the case of nurse-midwife services, as specified in § 440.165, are furnished by or under the direction of a physician or dentist; and
3. Are furnished by an institution that:
 - a. Is licensed or formally approved as a hospital by an officially designated authority for state standard-setting; and
 - b. Except in the case of medical supervision of nurse-midwife services, as specified in § 440.165, meets the requirements for participation in Medicare.

B. Reimbursement for induced abortions is provided in only those cases in which there would be substantial endangerment of health or life to the mother if the fetus were carried to term.

C. Reimbursement will not be provided for outpatient hospital services for any selected elective surgical procedures that require a second surgical opinion unless a

properly executed second surgical opinion form has been obtained from the physician and submitted with the invoice for payment, or is a justified emergency or exemption.

2b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

The same service limitations apply to rural health clinics as to all other services.

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with § 4231 of the State Medicaid Manual (HCFA Pub. 45-4).

The same service limitations apply to FQHCs as to all other services.

§ 3. Other laboratory and x-ray services.

Service must be ordered or prescribed and directed or performed within the scope of a license of the practitioner of the healing arts.

§ 4. Skilled nursing facility services, EPSDT and family planning.

4a. Skilled nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Service must be ordered or prescribed and directed or performed within the scope of a license of the practitioner of the healing arts.

4b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

A. Payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities, and the accompanying attendant physician care, in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination.

B. Routine physicals and immunizations (except as provided through EPSDT) are not covered except that well-child examinations in a private physician's office are covered for foster children of the local social services departments on specific referral from those departments.

C. Orthoptics services shall only be reimbursed if medically necessary to correct a visual defect identified by an EPSDT examination or evaluation. The department shall place appropriate utilization controls upon this service.

D. Consistent with the Omnibus Budget Reconciliation Act of 1989 § 6403, early and periodic screening, diagnostic, and treatment services means the following services: screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in the Social Security Act § 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services and which are medically necessary, whether or not such services are covered under the State Plan and notwithstanding the limitations, applicable to recipients ages 21 and over, provided for by the Act § 1905(a).

4c. Family planning services and supplies for individuals of child-bearing age.

A. Service must be ordered or prescribed and directed or performed within the scope of the license of a practitioner of the healing arts.

B. Family planning services shall be defined as those services which delay or prevent pregnancy. Coverage of such services shall not include services to treat infertility nor services to promote fertility.

§ 5. Physician's services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.

A. Elective surgery as defined by the Program is surgery that is not medically necessary to restore or materially improve a body function.

B. Cosmetic surgical procedures are not covered unless performed for physiological reasons and require Program prior approval.

C. Routine physicals and immunizations are not covered except when the services are provided under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program and when a well-child examination is performed in a private physician's office for a foster child of the local social services department on specific referral from those departments.

D. Psychiatric services are limited to an initial availability of 26 sessions, with one possible extension (subject to the approval of the Psychiatric Review Board) of 26 sessions during the first year of treatment. The availability is further restricted to no more than 26 sessions each succeeding year when approved by the Psychiatric Review Board. Psychiatric services are further restricted to no more than three sessions in any given seven-day period.

[These limitations also apply to psychotherapy sessions Psychiatric services can be provided] by [psychiatrists,] clinical psychologists licensed by the State Board of Medicine and , psychologists clinical licensed by the Board of Psychology , or by a licensed clinical social worker

under the direct supervision of a [psychiatrist,] licensed clinical psychologist or a licensed psychologist clinical .

E. Any procedure considered experimental is not covered.

F. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment of health or life to the mother if the fetus were carried to term.

G. Physician visits to inpatient hospital patients are limited to a maximum of 21 days per admission within 60 days for the same or similar diagnoses and is further restricted to medically necessary inpatient hospital days as determined by the Program.

EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination. Payments for physician visits for inpatient days determined to be medically unjustified will be adjusted.

H. Psychological testing and psychotherapy by clinical psychologists licensed by the State Board of Medicine and psychologists clinical licensed by the Board of Psychology are covered.

I. Repealed.

J. Reimbursement will not be provided for physician services performed in the inpatient setting for those surgical or diagnostic procedures listed on the mandatory outpatient surgery list unless the service is medically justified or meets one of the exceptions. The requirements of mandatory outpatient surgery do not apply to recipients in a retroactive eligibility period.

K. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Coverage of transplant services for all eligible persons is limited to transplants for kidneys and corneas. Kidney transplants require preauthorization. Cornea transplants do not require preauthorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. The amount of reimbursement for covered kidney transplant services is negotiable with the providers on an individual case basis. Reimbursement for covered cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in Attachment 3.1 E.

§ 6. Medical care by other licensed practitioners within

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the scope of their practice as defined by state law.

A. Podiatrists' services.

1. Covered podiatry services are defined as reasonable and necessary diagnostic, medical, or surgical treatment of disease, injury, or defects of the human foot. These services must be within the scope of the license of the podiatrists' profession and defined by state law.

2. The following services are not covered: preventive health care, including routine foot care; treatment of structural misalignment not requiring surgery; cutting or removal of corns, warts, or calluses; experimental procedures; acupuncture.

3. The Program may place appropriate limits on a service based on medical necessity or for utilization control, or both.

B. Optometrists' services.

Diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians, as allowed by the Code of Virginia and by regulations of the Boards of Medicine and Optometry, are covered for all recipients. Routine refractions are limited to once in 24 months except as may be authorized by the agency.

C. Chiropractors' services.

Not provided.

D. Other practitioners' services.

1. Clinical psychologists' services.

a. These limitations apply to psychotherapy sessions by clinical psychologists licensed by the State Board of Medicine and psychologists clinical licensed by the Board of Psychology. Psychiatric services are limited to an initial availability of 26 sessions, with one possible extension of 26 sessions during the first year of treatment. The availability is further restricted to no more than 26 sessions each succeeding year when approved by the Psychiatric Review Board. Psychiatric services are further restricted to no more than three sessions in any given seven-day period.

b. Psychological testing and psychotherapy by clinical psychologists licensed by the State Board of Medicine and psychologists clinical licensed by the Board of Psychology are covered.

§ 7. Home health services.

A. Service must be ordered or prescribed and directed or performed within the scope of a license of a

practitioner of the healing arts.

B. Nursing services provided by a home health agency.

1. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

2. Patients may receive up to 32 visits by a licensed nurse annually. Limits are per recipient, regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient. If services beyond these limitations are determined by the physician to be required, then the provider shall request prior authorization from DMAS for additional services. Payment shall not be made for additional service unless authorized by DMAS.

C. Home health aide services provided by a home health agency.

1. Home health aides must function under the supervision of a professional nurse.

2. Home health aides must meet the certification requirements specified in 42 CFR 484.36.

3. For home health aide services, patients may receive up to 32 visits annually. Limits shall be per recipient, regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient.

D. Medical supplies, equipment, and appliances suitable for use in the home.

1. All medically necessary supplies, equipment, and appliances are covered for patients of the home health agency. Unusual amounts, types, and duration of usage must be authorized by DMAS in accordance with published policies and procedures. When determined to be cost-effective by DMAS, payment may be made for rental of the equipment in lieu of purchase.

2. Medical supplies, equipment, and appliances for all others are limited to home renal dialysis equipment and supplies, respiratory equipment and oxygen, and ostomy supplies, as authorized by the agency.

3. Supplies, equipment, or appliances that are not covered include, but are not limited to, the following:

a. Space conditioning equipment, such as room humidifiers, air cleaners, and air conditioners.

b. Durable medical equipment and supplies for any hospital or nursing facility resident, except ventilators and associated supplies for nursing facility residents that have been approved by DMAS central office.

c. Furniture or appliances not defined as medical equipment (such as blenders, bedside tables, mattresses other than for a hospital bed, pillows, blankets or other bedding, special reading lamps, chairs with special lift seats, hand-held shower devices, exercise bicycles, and bathroom scales).

d. Items that are only for the recipient's comfort and convenience or for the convenience of those caring for the recipient (e.g., a hospital bed or mattress because the recipient does not have a decent bed; wheelchair trays used as a desk surface); mobility items used in addition to primary assistive mobility aide for caregiver's or recipient's convenience (i.e., electric wheelchair plus a manual chair); cleansing wipes.

e. Prosthesis, except for artificial arms, legs, and their supportive devices which must be preauthorized by the DMAS central office (effective July 1, 1989).

f. Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (for example, over-the-counter drugs; dentifrices; toilet articles; shampoos which do not require a physician's prescription; dental adhesives; electric toothbrushes; cosmetic items, soaps, and lotions which do not require a physician's prescription; sugar and salt substitutes; support stockings; and nonlegend drugs).

g. Orthotics, including braces, splints, and supports.

h. Home or vehicle modifications.

i. Items not suitable for or used primarily in the home setting (i.e., car seats, equipment to be used while at school, etc.).

j. Equipment that the primary function is vocationally or educationally related (i.e., computers, environmental control devices, speech devices, etc.).

4. For coverage of blood glucose meters for pregnant women, refer to Supplement 3 to Attachments 3.1 A and B.

E. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

1. Service covered only as part of a physician's plan of care.

2. Patients may receive up to 24 visits for each rehabilitative therapy service ordered annually *without authorization*. Limits shall apply per recipient regardless of the number of providers rendering services. Annually shall be defined as July 1 through

June 30 for each recipient. If services beyond these limitations are determined by the physician to be required, then the provider shall request prior authorization from DMAS for additional services.

F. *The following services are not covered under the home health services program:*

1. *Medical social services;*

2. *Services or items which would not be paid for if provided to an inpatient of a hospital, such as private-duty nursing services, or items of comfort which have no medical necessity, such as television;*

3. *Community food service delivery arrangements;*

4. *Domestic or housekeeping services which are unrelated to patient care and which materially increase the time spent on a visit;*

5. *Custodial care which is patient care that primarily requires protective services rather than definitive medical and skilled nursing care; and*

6. *Services related to cosmetic surgery.*

§ 8. Private duty nursing services.

Not provided.

§ 9. Clinic services.

A. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment of health or life to the mother if the fetus was carried to term.

B. Clinic services means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that:

1. Are provided to outpatients;

2. Are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients; and

3. Except in the case of nurse-midwife services, as specified in 42 dentist.

§ 10. Dental services.

A. Dental services are limited to recipients under 21 years of age in fulfillment of the treatment requirements under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program and defined as routine diagnostic, preventive, or restorative procedures necessary for oral health provided by or under the direct supervision of a dentist in accordance with the State Dental Practice Act.

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B. Initial, periodic, and emergency examinations; required radiography necessary to develop a treatment plan; patient education; dental prophylaxis; fluoride treatments; dental sealants; routine amalgam and composite restorations; crown recementation; pulpotomies; emergency endodontics for temporary relief of pain; pulp capping; sedative fillings; therapeutic apical closure; topical palliative treatment for dental pain; removal of foreign body; simple extractions; root recovery; incision and drainage of abscess; surgical exposure of the tooth to aid eruption; sequestrectomy for osteomyelitis; and oral antral fistula closure are dental services covered without preauthorization by the state agency.

C. All covered dental services not referenced above require preauthorization by the state agency. The following services are also covered through preauthorization: medically necessary full banded orthodontics, for handicapping malocclusions, minor tooth guidance or repositioning appliances, complete and partial dentures, surgical preparation (alveoloplasty) for prosthetics, single permanent crowns, and bridges. The following service is not covered: routine bases under restorations.

D. The state agency may place appropriate limits on a service based on medical necessity, for utilization control, or both. Examples of service limitations are: examinations, prophylaxis, fluoride treatment (once/six months); space maintenance appliances; bitewing x-ray — two films (once/12 months); routine amalgam and composite restorations (once/three years); dentures (once per 5 years); extractions, orthodontics, tooth guidance appliances, permanent crowns, and bridges, endodontics, patient education and sealants (once).

E. Limited oral surgery procedures, as defined and covered under Title XVIII (Medicare), are covered for all recipients, and also require preauthorization by the state agency.

§ 11. Physical therapy and related services.

Physical therapy and related services shall be defined as physical therapy, occupational therapy, and speech-language pathology services. These services shall be prescribed by a physician and be part of a written plan of care. Any one of these services may be offered as the sole service and shall not be contingent upon the provision of another service. All practitioners and providers of services shall be required to meet state and federal licensing and/or certification requirements.

11a. Physical therapy.

A. Services for individuals requiring physical therapy are provided only as an element of hospital inpatient or outpatient service, nursing facility service, home health service, services provided by a local school division employing qualified therapists, or when otherwise included as an authorized service by a cost provider who provides rehabilitation services.

B. Effective July 1, 1988, the Program will not provide direct reimbursement to enrolled providers for physical therapy service rendered to patients residing in long term care facilities. Reimbursement for these services is and continues to be included as a component of the nursing homes' operating cost.

C. Physical therapy services meeting all of the following conditions shall be furnished to patients:

1. Physical therapy services shall be directly and specifically related to an active written care plan designed by a physician after any needed consultation with a physical therapist licensed by the Board of Medicine;
2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a physical therapist licensed by the Board of Medicine, or a physical therapy assistant who is licensed by the Board of Medicine and is under the direct supervision of a physical therapist licensed by the Board of Medicine. When physical therapy services are provided by a qualified physical therapy assistant, such services shall be provided under the supervision of a qualified physical therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.
3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

11b. Occupational therapy.

A. Services for individuals requiring occupational therapy are provided only as an element of hospital inpatient or outpatient service, nursing facility service, home health service, services provided by a local school division employing qualified therapists, or when otherwise included as an authorized service by a cost provider who provides rehabilitation services.

B. Effective September 1, 1990, Virginia Medicaid will not make direct reimbursement to providers for occupational therapy services for Medicaid recipients residing in long-term care facilities. Reimbursement for these services is and continues to be included as a component of the nursing facilities' operating cost.

C. Occupational therapy services shall be those services furnished a patient which meet all of the following conditions:

1. Occupational therapy services shall be directly and specifically related to an active written care plan designed by a physician after any needed consultation with an occupational therapist registered and certified

by the American Occupational Therapy Certification Board.

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by an occupational therapist registered and certified by the American Occupational Therapy Certification Board, a graduate of a program approved by the Council on Medical Education of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association when under the supervision of an occupational therapist defined above, or an occupational therapy assistant who is certified by the American Occupational Therapy Certification Board under the direct supervision of an occupational therapist as defined above. When occupational therapy services are provided by a qualified occupational therapy assistant or a graduate engaged in supplemental clinical experience required before registration, such services shall be provided under the supervision of a qualified occupational therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

11c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist; see Page 1, General and Page 12, Physical Therapy and Related Services.)

A. These services are provided by or under the supervision of a speech pathologist or an audiologist only as an element of hospital inpatient or outpatient service, nursing facility service, home health service, services provided by a local school division employing qualified therapists, or when otherwise included as an authorized service by a cost provider who provides rehabilitation services.

B. Effective September 1, 1990, Virginia Medicaid will not make direct reimbursement to providers for speech-language pathology services for Medicaid recipients residing in long-term care facilities. Reimbursement for these services is and continues to be included as a component of the nursing facilities' operating cost.

C. Speech-language pathology services shall be those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a

speech-language pathologist licensed by the Board of Audiology and Speech-Language Pathology, or, if exempted from licensure by statute, meeting the requirements in 42 CFR 440.110(c);

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by or under the direction of a speech-language pathologist who meets the qualifications in number 1. The program shall meet the requirements of 42 CFR 405.1719(c). At least one qualified speech-language pathologist must be present at all times when speech-language pathology services are rendered; and

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

11d. Authorization for services.

A. Physical therapy, occupational therapy, and speech-language pathology services provided in outpatient settings of acute and rehabilitation hospitals, rehabilitation agencies, *school divisions*, or home health agencies shall include authorization for up to 24 visits by each ordered rehabilitative service *within a 60-day period annually*. *A recipient may receive a maximum of 48 visits annually without authorization.* The provider shall maintain documentation to justify the need for services.

B. The provider shall request from DMAS authorization for treatments deemed necessary by a physician beyond the number authorized. *This request must be signed and dated by a physician. Documentation for medical justification must include physician orders or a plan of care signed and dated by a physician.* Authorization for extended services shall be based on individual need. Payment shall not be made for additional service unless the extended provision of services has been authorized by DMAS.

11e. Documentation requirements.

A. Documentation of physical therapy, occupational therapy, and speech-language pathology services provided by a hospital-based outpatient setting, home health agency, a school division, or a rehabilitation agency shall, at a minimum:

1. Describe the clinical signs and symptoms of the patient's condition;
2. Include an accurate and complete chronological picture of the patient's clinical course and treatments;
3. Document that a plan of care specifically designed for the patient has been developed based upon a comprehensive assessment of the patient's needs;

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4. Include a copy of the physician's orders and plan of care;

5. Include all treatment rendered to the patient in accordance with the plan with specific attention to frequency, duration, modality, response, and identify who provided care (include full name and title);

6. Describe changes in each patient's condition and response to the rehabilitative treatment plan;

7. (Except for school divisions) describe a discharge plan which includes the anticipated improvements in functional levels, the time frames necessary to meet these goals, and the patient's discharge destination; and

8. In school divisions, include an individualized education program (IEP) which describes the anticipated improvements in functional level in each school year and the time frames necessary to meet these goals.

B. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

11f. Service limitations. The following general conditions shall apply to reimbursable physical therapy, occupational therapy, and speech-language pathology:

A. Patient must be under the care of a physician who is legally authorized to practice and who is acting within the scope of his license.

B. Services shall be furnished under a written plan of treatment and must be established and periodically reviewed by a physician. The requested services or items must be necessary to carry out the plan of treatment and must be related to the patient's condition.

C. A physician recertification shall be required periodically, must be signed and dated by the physician who reviews the plan of treatment, and may be obtained when the plan of treatment is reviewed. The physician recertification statement must indicate the continuing need for services and should estimate how long rehabilitative services will be needed.

D. The physician orders for therapy services shall include the specific procedures and modalities to be used, identify the specific discipline to carry out the plan of care, and indicate the frequency and duration for services.

E. Utilization review shall be performed to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and

no coverage shall be provided.

F. Physical therapy, occupational therapy and speech-language services are to be terminated regardless of the approved length of stay when further progress toward the established rehabilitation goal is unlikely or when the services can be provided by someone other than the skilled rehabilitation professional.

§ 12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

12a. Prescribed drugs.

A. Drugs for which Federal Financial Participation is not available, pursuant to the requirements of § 1927 of the Social Security Act (OBRA '90 § 4401), shall not be covered except for over-the-counter drugs when prescribed for nursing facility residents.

B. The following prescribed, nonlegend drugs/drug devices shall be covered: (i) insulin, (ii) syringes, (iii) needles, (iv) diabetic test strips for clients under 21 years of age, (v) family planning supplies, and (vi) those prescribed to nursing home residents.

C. Legend drugs are covered, with the exception of anorexiant drugs prescribed for weight loss and the drugs for classes of drugs identified in Supplement 5.

D. Notwithstanding the provisions of § 32.1-87 of the Code of Virginia, and in compliance with the provision of § 4401 of the Omnibus Reconciliation Act of 1990, § 1927(e) of the Social Security Act as amended by OBRA 90, and pursuant to the authority provided for under § 32.1-325 A of the Code of Virginia, prescriptions for Medicaid recipients for multiple source drugs subject to 42 CFR § 447.332 shall be filled with generic drug products unless the physician or other practitioners so licensed and certified to prescribe drugs certifies in his own handwriting "brand necessary" for the prescription to be dispensed as written.

E. New drugs shall be covered in accordance with the Social Security Act § 1927(d) (OBRA 90 § 4401).

F. The number of refills shall be limited pursuant to § 54.1-3411 of the Drug Control Act.

G. Drug prior authorization.

1. Definitions.

"Board" means the Board for Medical Assistance Services.

"Committee" means the Medicaid Prior Authorization Advisory Committee.

"Department" means the Department of Medical

Assistance Services.

"Director" means the Director of Medical Assistance Services.

"Drug" shall have the same meaning, unless the context otherwise dictates or the Board otherwise provides by regulation, as provided in the Drug Control Act (§ 54.1-3400 et seq.)

2. Medicaid Prior Authorization Advisory Committee; membership. The Medicaid Prior Authorization Committee shall consist of 10 members to be appointed by the board. Five members shall be physicians, at least three of whom shall care for a significant number of Medicaid patients; four shall be pharmacists, two of whom shall be community pharmacists; and one shall be a Medicaid recipient.

a. A quorum for action by the committee shall consist of six members.

b. The members shall serve at the pleasure of the board; vacancies shall be filled in the same manner as the original appointment.

c. The board shall consider nominations made by the Medical Society of Virginia, the Old Dominion Medical Society and the Virginia Pharmaceutical Association when making appointments to the committee.

d. The committee shall elect its own officers, establish its own procedural rules, and meet as needed or as called by the board, the director, or any two members of the committee. The department shall provide appropriate staffing to the committee.

3. Duties of the committee.

a. The committee shall make recommendations to the board regarding drugs or categories of drugs to be subject to prior authorization, prior authorization requirements for prescription drug coverage and any subsequent amendments to or revisions of the prior authorization requirements. The board may accept or reject the recommendations in whole or in part, and may amend or add to the recommendations, except that the board may not add to the recommendation of drugs and categories of drugs to be subject to prior authorization.

b. In formulating its recommendations to the board, the committee shall not be deemed to be formulating regulations for the purposes of the Administrative Process Act (§ 9-6.14:1 et seq.). The committee shall, however, conduct public hearings prior to making recommendations to the board. The committee shall give 30 days written notice by mail of the time and place of its hearings and meetings to any manufacturer whose product is being

reviewed by the committee and to those manufacturers who request of the committee in writing that they be informed of such hearings and meetings. These persons shall be afforded a reasonable opportunity to be heard and present information. The committee shall give 30 days notice of such public hearings to the public by publishing its intention to conduct hearings and meetings in the Calendar of Events of The Virginia Register of Regulations and a newspaper of general circulation located in Richmond.

c. In acting on the recommendations of the committee, the board shall conduct further proceedings under the Administrative Process Act.

4. Prior authorization of prescription drug products, coverage.

a. The committee shall review prescription drug products to recommend prior authorization under the state plan. This review may be initiated by the director, the committee itself, or by written request of the board. The committee shall complete its recommendations to the board within no more than six months from receipt of any such request.

b. Coverage for any drug requiring prior authorization shall not be approved unless a prescribing physician obtains prior approval of the use in accordance with regulations promulgated by the board and procedures established by the department.

c. In formulating its recommendations to the board, the committee shall consider the potential impact on patient care and the potential fiscal impact of prior authorization on pharmacy, physician, hospitalization and outpatient costs. Any proposed regulation making a drug or category of drugs subject to prior authorization shall be accompanied by a statement of the estimated impact of this action on pharmacy, physician, hospitalization and outpatient costs.

d. The committee shall not review any drug for which it has recommended or the board has required prior authorization within the previous 12 months, unless new or previously unavailable relevant and objective information is presented.

e. Confidential proprietary information identified as such by a manufacturer or supplier in writing in advance and furnished to the committee or the board according to this subsection shall not be subject to the disclosure requirements of the Virginia Freedom of Information Act (§ 2.1-340 et seq.). The board shall establish by regulation the means by which such confidential proprietary information shall be protected.

5. Immunity. The members of the committee and the

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board and the staff of the department shall be immune, individually and jointly, from civil liability for any act, decision, or omission done or made in performance of their duties pursuant to this subsection while serving as a member of such board, committee, or staff provided that such act, decision, or omission is not done or made in bad faith or with malicious intent.

6. Annual report to joint commission. The committee shall report annually to the Joint Commission on Health Care regarding its recommendations for prior authorization of drug products.

12b. Dentures.

Provided only as a result of EPSDT and subject to medical necessity and preauthorization requirements specified under Dental Services.

12c. Prosthetic devices.

A. Prosthetics services shall mean the replacement of missing arms and legs. Nothing in this regulation shall be construed to refer to orthotic services or devices.

B. Prosthetic devices (artificial arms and legs, and their necessary supportive attachments) are provided when prescribed by a physician or other licensed practitioner of the healing arts within the scope of their professional licenses as defined by state law. This service, when provided by an authorized vendor, must be medically necessary, and preauthorized for the minimum applicable component necessary for the activities of daily living.

12d. Eyeglasses.

Eyeglasses shall be reimbursed for all recipients younger than 21 years of age according to medical necessity when provided by practitioners as licensed under the Code of Virginia.

§ 13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13a. Diagnostic services.

Not provided.

13b. Screening services.

Screening mammograms for the female recipient population aged 35 and over shall be covered, consistent with the guidelines published by the American Cancer Society.

13c. Preventive services.

Not provided.

13d. Rehabilitative services.

A. Intensive physical rehabilitation.

1. Medicaid covers intensive inpatient rehabilitation services as defined in subdivision A 4 in facilities certified as rehabilitation hospitals or rehabilitation units in acute care hospitals which have been certified by the Department of Health to meet the requirements to be excluded from the Medicare Prospective Payment System.

2. Medicaid covers intensive outpatient physical rehabilitation services as defined in subdivision A 4 in facilities which are certified as Comprehensive Outpatient Rehabilitation Facilities (CORFs).

3. These facilities are excluded from the 21-day limit otherwise applicable to inpatient hospital services. Cost reimbursement principles are defined in Attachment 4.19-A.

4. An intensive rehabilitation program provides intensive skilled rehabilitation nursing, physical therapy, occupational therapy, and, if needed, speech therapy, cognitive rehabilitation, prosthetic-orthotic services, psychology, social work, and therapeutic recreation. The nursing staff must support the other disciplines in carrying out the activities of daily living, utilizing correctly the training received in therapy and furnishing other needed nursing services. The day-to-day activities must be carried out under the continuing direct supervision of a physician with special training or experience in the field of rehabilitation.

5. Nothing in this regulation is intended to preclude DMAS from negotiating individual contracts with in-state intensive physical rehabilitation facilities for those individuals with special intensive rehabilitation needs.

B. Community mental health services.

Definitions. The following words and terms, when used in these regulations, shall have the following meanings unless the context clearly indicates otherwise:

“Code” means the Code of Virginia.

“DMAS” means the Department of Medical Assistance Services consistent with Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 of the Code of Virginia.

“DMHMRSAS” means Department of Mental Health, Mental Retardation and Substance Abuse Services consistent with Chapter 1 (§ 37.1-39 et seq.) of Title 37.1 of the Code of Virginia.

1. Mental health services. The following services, with their definitions, shall be covered:

a. Intensive in-home services for children and adolescents under age 21 shall be time-limited interventions provided typically but not solely in the residence of an individual who is at risk of being moved into an out-of-home placement or who is being transitioned to home from out-of-home placement due to a disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders-III-R (DSM-III-R). These services provide crisis treatment; individual and family counseling; life (e.g., counseling to assist parents to understand and practice proper child nutrition, child health care, personal hygiene, and financial management, etc.), parenting (e.g., counseling to assist parents to understand and practice proper nurturing and discipline, and behavior management, etc.), and communication skills (e.g., counseling to assist parents to understand and practice appropriate problem-solving, anger management, and interpersonal interaction, etc.); case management activities and coordination with other required services; and 24-hour emergency response. These services shall be limited annually to 26 weeks.

b. Therapeutic day treatment for children and adolescents shall be provided in sessions of two or more hours per day, to groups of seriously emotionally disturbed children and adolescents or children at risk of serious emotional disturbance in order to provide therapeutic interventions. Day treatment programs, limited annually to 780 units, provide evaluation, medication education and management, opportunities to learn and use daily living skills and to enhance social and interpersonal skills (e.g., problem solving, anger management, community responsibility, increased impulse control and appropriate peer relations, etc.), and individual, group and family counseling.

c. Day treatment/partial hospitalization services for adults shall be provided in sessions of two or more consecutive hours per day, which may be scheduled multiple times per week, to groups of individuals in a nonresidential setting. These services, limited annually to 780 units, include the major diagnostic, medical, psychiatric, psychosocial and psychoeducational treatment modalities designed for individuals with serious mental disorders who require coordinated, intensive, comprehensive, and multidisciplinary treatment.

d. Psychosocial rehabilitation for adults shall be provided in sessions of two or more consecutive hours per day to groups of individuals in a nonresidential setting. These services, limited annually to 936 units, include assessment, medication education, psychoeducation, opportunities to learn and use independent living skills and to enhance social and interpersonal skills, family support, and education within a supportive and normalizing program structure and environment.

e. Crisis intervention shall provide immediate mental health care, available 24 hours a day, seven days per week, to assist individuals who are experiencing acute mental dysfunction requiring immediate clinical attention. This service's objectives shall be to prevent exacerbation of a condition, to prevent injury to the client or others, and to provide treatment in the context of the least restrictive setting. Crisis intervention activities, limited annually to 180 hours, shall include assessing the crisis situation, providing short-term counseling designed to stabilize the individual or the family unit or both, providing access to further immediate assessment and follow-up, and linking the individual and family with ongoing care to prevent future crises. Crisis intervention services may include, but are not limited to, office visits, home visits, preadmission screenings, telephone contacts, and other client-related activities for the prevention of institutionalization.

2. Mental retardation services. Day health and rehabilitation services shall be covered and the following definitions shall apply:

Day health and rehabilitation services (limited to 780 units per year) shall provide individualized activities, supports, training, supervision, and transportation based on a written plan of care to eligible persons for two or more hours per day scheduled multiple times per week. These services are intended to improve the recipient's condition or to maintain an optimal level of functioning, as well as to ameliorate the recipient's disabilities or deficits by reducing the degree of impairment or dependency. Therapeutic consultation to service providers, family, and friends of the client around implementation of the plan of care may be included as part of the services provided by the day health and rehabilitation program. The provider shall be licensed by DMHMRSAS as a Day Support Program. Specific components of day health and rehabilitation services include the following as needed:

- (1) Self-care and hygiene skills;
- (2) Eating and toilet training skills;
- (3) Task learning skills;
- (4) Community resource utilization skills (e.g., training in time, telephone, basic computations with money, warning sign recognition, and personal identifications, etc.);
- (5) Environmental and behavior skills (e.g., training in punctuality, self-discipline, care of personal belongings and respect for property and in wearing proper clothing for the weather, etc.);
- (6) Medication management;

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(7) Travel and related training to and from the training sites and service and support activities;

(8) Skills related to the above areas, as appropriate that will enhance or retain the recipient's functioning.

§ 14. Services for individuals age 65 or older in institutions for mental diseases.

14a. Inpatient hospital services.

Provided, no limitations.

14b. Skilled nursing facility services.

Provided, no limitations.

14c. Intermediate care facility.

Provided, no limitations.

§ 15. Intermediate care services and intermediate care services for institutions for mental disease and mental retardation.

15a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with § 1902 (a)(31)(A) of the Act, to be in need of such care.

Provided, no limitations.

15b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

Provided, no limitations.

§ 16. Inpatient psychiatric facility services for individuals under 22 years of age.

Not provided.

§ 17. Nurse-midwife services.

Covered services for the nurse midwife are defined as those services allowed under the licensure requirements of the state statute and as specified in the Code of Federal Regulations, i.e., maternity cycle.

§ 18. Hospice care (in accordance with § 1905 (o) of the Act).

A. Covered hospice services shall be defined as those services allowed under the provisions of Medicare law and regulations as they relate to hospice benefits and as specified in the Code of Federal Regulations, Title 42, Part 418.

B. Categories of care.

As described for Medicare and applicable to Medicaid, hospice services shall entail the following four categories of daily care:

1. Routine home care is at-home care that is not continuous.

2. Continuous home care consists of at-home care that is predominantly nursing care and is provided as short-term crisis care. A registered or licensed practical nurse must provide care for more than half of the period of the care. Home health aide or homemaker services may be provided in addition to nursing care. A minimum of eight hours of care per day must be provided to qualify as continuous home care.

3. Inpatient respite care is short-term inpatient care provided in an approved facility (freestanding hospice, hospital, or nursing facility) to relieve the primary caregiver(s) providing at-home care for the recipient. Respite care is limited to not more than five consecutive days.

4. General inpatient care may be provided in an approved freestanding hospice, hospital, or nursing facility. This care is usually for pain control or acute or chronic symptom management which cannot be successfully treated in another setting.

C. Covered services.

1. As required under Medicare and applicable to Medicaid, the hospice itself shall provide all or substantially all of the "core" services applicable for the terminal illness which are nursing care, physician services, social work, and counseling (bereavement, dietary, and spiritual).

2. Other services applicable for the terminal illness that shall be available but are not considered "core" services are drugs and biologicals, home health aide and homemaker services, inpatient care, medical supplies, and occupational and physical therapies and speech-language pathology services.

3. These other services may be arranged, such as by contractual agreement, or provided directly by the hospice.

4. To be covered, a certification that the individual is terminally ill shall have been completed by the physician and hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. The individual must elect hospice care and a plan of care must be established before services are provided. To be covered, services shall be consistent with the plan of care. Services not specifically documented in the patient's medical record as having been rendered will be deemed not to have been rendered and no

coverage will be provided.

5. All services shall be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service. The following services are covered hospice services:

a. Nursing care. Nursing care shall be provided by a registered nurse or by a licensed practical nurse under the supervision of a graduate of an approved school of professional nursing and who is licensed as a registered nurse.

b. Medical social services. Medical social services shall be provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.

c. Physician services. Physician services shall be performed by a professional who is licensed to practice, who is acting within the scope of his or her license, and who is a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor. The hospice medical director or the physician member of the interdisciplinary team shall be a licensed doctor of medicine or osteopathy.

d. Counseling services. Counseling services shall be provided to the terminally ill individual and the family members or other persons caring for the individual at home. Bereavement counseling consists of counseling services provided to the individual's family up to one year after the individual's death. Bereavement counseling is a required hospice service, but it is not reimbursable.

e. Short-term inpatient care. Short-term inpatient care may be provided in a participating hospice inpatient unit, or a participating hospital or nursing facility. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home.

f. Durable medical equipment and supplies. Durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness is covered. Medical supplies include those that are part of the written plan of care.

g. Drugs and biologicals. Only drugs used which are

used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered.

h. Home health aide and homemaker services. Home health aides providing services to hospice recipients must meet the qualifications specified for home health aides by 42 CFR 484.36. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care. Home health aide and homemaker services must be provided under the general supervision of a registered nurse.

i. Rehabilitation services. Rehabilitation services include physical and occupational therapies and speech-language pathology services that are used for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

D. Eligible groups.

To be eligible for hospice coverage under Medicare or Medicaid, the recipient must have a life expectancy of six months or less, have knowledge of the illness and life expectancy, and elect to receive hospice services rather than active treatment for the illness. Both the attending physician and the hospice medical director must certify the life expectancy. The hospice must obtain the certification that an individual is terminally ill in accordance with the following procedures:

1. For the first 90-day period of hospice coverage, the hospice must obtain, within two calendar days after the period begins, a written certification statement signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician if the individual has an attending physician. For the initial 90-day period, if the hospice cannot obtain written certifications within two calendar days, it must obtain oral certifications within two calendar days, and written certifications no later than eight calendar days after the period begins.

2. For any subsequent 90-day or 30-day period or a subsequent extension period during the individual's lifetime, the hospice must obtain, no later than two calendar days after the beginning of that period, a written certification statement prepared by the medical director of the hospice or the physician member of the hospice's interdisciplinary group. The certification must include the statement that the

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individual's medical prognosis is that his or her life expectancy is six months or less and the signature(s) of the physician(s). The hospice must maintain the certification statements.

§ 19. Case management services for high-risk pregnant women and children up to age 1, as defined in Supplement 2 to Attachment 3.1-A in accordance with § 1915(g)(1) of the Act.

Provided, with limitations. See Supplement 2 for detail.

§ 20. Extended services to pregnant women.

20a. Pregnancy-related and postpartum services for 60 days after the pregnancy ends.

The same limitations on all covered services apply to this group as to all other recipient groups.

20b. Services for any other medical conditions that may complicate pregnancy.

The same limitations on all covered services apply to this group as to all other recipient groups.

§ 21. Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary of Health and Human Services.

21a. Transportation.

Transportation services are provided to Virginia Medicaid recipients to ensure that they have necessary access to and from providers of all medical services. Both emergency and nonemergency services are covered. The single state agency may enter into contracts with friends of recipients, nonprofit private agencies, and public carriers to provide transportation to Medicaid recipients.

21b. Services of Christian Science nurses.

Not provided.

21c. Care and services provided in Christian Science sanatoria.

Provided, no limitations.

21d. Skilled nursing facility services for patients under 21 years of age.

Provided, no limitations.

21e. Emergency hospital services.

Provided, no limitations.

21f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a

registered nurse.

Not provided.

§ 22. Emergency Services for Aliens.

A. No payment shall be made for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law unless such services are necessary for the treatment of an emergency medical condition of the alien.

B. Emergency services are defined as:

Emergency treatment of accidental injury or medical condition (including emergency labor and delivery) manifested by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical/surgical attention could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part.

C. Medicaid eligibility and reimbursement is conditional upon review of necessary documentation supporting the need for emergency services. Services and inpatient lengths of stay cannot exceed the limits established for other Medicaid recipients.

D. Claims for conditions which do not meet emergency criteria for treatment in an emergency room or for acute care hospital admissions for intensity of service or severity of illness will be denied reimbursement by the Department of Medical Assistance Services.

VR 460-02-3.1300. Standards Established and Methods Used to Assure High Quality Care.

The following is a description of the standards and the methods that will be used to assure that the medical and remedial care and services are of high quality:

§ 1. Institutional care will be provided by facilities qualified to participate in Title XVIII and/or Title XIX.

§ 2. Utilization control.

A. General acute care hospitals.

1. The Commonwealth of Virginia is required by state law to take affirmative action on all hospital stays that approach 15 days. It is a requirement that the hospitals submit to the Department of Medical Assistance Services complete information on all hospital stays where there is a need to exceed 15 days. The various documents which are submitted are

reviewed by professional program staff, including a physician who determines if additional hospitalization is indicated. This review not only serves as a mechanism for approving additional days, but allows physicians on the Department of Medical Assistance Services' staff to evaluate patient documents and give the Program an insight into the quality of care by individual patient. In addition, hospital representatives of the Medical Assistance Program visit hospitals, review the minutes of the Utilization Review Committee, discuss patient care, and discharge planning.

2. In each case for which payment for inpatient hospital services, or inpatient mental hospital services is made under the State Plan:

a. A physician must certify at the time of admission, or if later, the time the individual applies for medical assistance under the State Plan that the individual requires inpatient hospital or mental hospital care.

b. The physician, or physician assistant under the supervision of a physician, must recertify, at least every 60 days, that patients continue to require inpatient hospital or mental hospital care.

c. Such services were furnished under a plan established and periodically reviewed and evaluated by a physician for inpatient hospital or mental hospital services.

B. Long-stay acute care hospitals (nonmental hospitals).

1. Services for adults in long-stay acute care hospitals. The population to be served includes individuals requiring mechanical ventilation, ongoing intravenous medication or nutrition administration, comprehensive rehabilitative therapy services and individuals with communicable diseases requiring universal or respiratory precautions.

a. Long-stay acute care hospital stays shall be preauthorized by the submission of a completed comprehensive assessment instrument, a physician certification of the need for long-stay acute care hospital placement, and any additional information that justifies the need for intensive services. Physician certification must accompany the request. Periods of care not authorized by DMAS shall not be approved for payment.

b. These individuals must have long-term health conditions requiring close medical supervision, the need for 24-hour licensed nursing care, and the need for specialized services or equipment needs.

c. At a minimum, these individuals must require physician visits at least once weekly, licensed nursing services 24 hours a day (a registered nurse

whose sole responsibility is the designated unit must be on the nursing unit 24 hours a day on which the resident resides), and coordinated multidisciplinary team approach to meet needs that must include daily therapeutic leisure activities.

d. In addition, the individual must meet at least one of the following requirements:

(1) Must require two out of three of the following rehabilitative services: physical therapy, occupational therapy, speech-pathology services; each required therapy must be provided daily, five days per week, for a minimum of one hour each day; individual must demonstrate progress in overall rehabilitative plan of care on a monthly basis; or

(2) Must require special equipment such as mechanical ventilators, respiratory therapy equipment (that has to be supervised by a licensed nurse or respiratory therapist), monitoring device (respiratory or cardiac), kinetic therapy; or

(3) The individual must require at least one of the following special services:

(a) Ongoing administration of intravenous medications or nutrition (i.e. total parenteral nutrition (TPN), antibiotic therapy, narcotic administration, etc.);

(b) Special infection control precautions such as universal or respiratory precaution (this does not include handwashing precautions only);

(c) Dialysis treatment that is provided on-unit (i.e. peritoneal dialysis);

(d) Daily respiratory therapy treatments that must be provided by a licensed nurse or a respiratory therapist;

(e) Extensive wound care requiring debridement, irrigation, packing, etc., more than two times a day (i.e. grade IV decubiti; large surgical wounds that cannot be closed; second- or third-degree burns covering more than 10% of the body); or

(f) Ongoing management of multiple unstable ostomies (a single ostomy does not constitute a requirement for special care) requiring frequent care (i.e. suctioning every hour; stabilization of feeding; stabilization of elimination, etc.).

e. Utilization review shall be performed to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the individuals' medical records as having been rendered shall be deemed not to have been

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rendered and no coverage shall be provided.

f. When the individual no longer meets long-stay acute care hospital criteria or requires services that the facility is unable to provide, then the individual must be discharged.

2. Services to pediatric/adolescent patients in long-stay acute care hospitals. The population to be served shall include children requiring mechanical ventilation, ongoing intravenous medication or nutrition administration, daily dependence on device-based respiratory or nutritional support (tracheostomy, gastrostomy, etc.), comprehensive rehabilitative therapy services, and those children having communicable diseases requiring universal or respiratory precautions (excluding normal childhood diseases such as chicken pox, measles, strep throat, etc.) and with terminal illnesses.

a. Long-stay acute care hospital stays shall be preauthorized by the submission of a completed comprehensive assessment instrument, a physician certification of the need for long-stay acute care, and any additional information that justifies the need for intensive services. Periods of care not authorized by DMAS shall not be approved for payment.

b. The child must have ongoing health conditions requiring close medical supervision, the need for 24-hour licensed nursing supervision, and the need for specialized services or equipment. The recipient must be age 21 or under.

c. The child must minimally require physician visits at least once weekly, licensed nursing services 24 hours a day (a registered nurse whose sole responsibility is that nursing unit must be on the unit 24 hours a day on which the child is residing), and a coordinated multidisciplinary team approach to meet needs.

d. In addition, the child must meet one of the following requirements:

(1) Must require two out of three of the following physical rehabilitative services: physical therapy, occupational therapy, speech-pathology services; each required therapy must be provided daily, five days per week, for a minimum of 45 minutes per day; child must demonstrate progress in overall rehabilitative plan of care on a monthly basis; or

(2) Must require special equipment such as mechanical ventilators, respiratory therapy equipment (that has to be supervised by licensed nurse or respiratory therapist), monitoring device (respiratory or cardiac), kinetic therapy, etc; or

(3) Must require at least one of the following

special services:

(a) Ongoing administration of intravenous medications or nutrition (i.e. total parenteral nutrition (TPN), antibiotic therapy, narcotic administration, etc.);

(b) Special infection control precautions such as universal or respiratory precaution (this does not include handwashing precautions only or isolation for normal childhood diseases such as measles, chicken pox, strep throat, etc.);

(c) Dialysis treatment that is provided within the facility (i.e. peritoneal dialysis);

(d) Daily respiratory therapy treatments that must be provided by a licensed nurse or a respiratory therapist;

(e) Extensive wound care requiring debridement, irrigation, packing, etc. more than two times a day (i.e. grade IV decubiti; large surgical wounds that cannot be closed; second- or third-degree burns covering more than 10% of the body);

(f) Ostomy care requiring services by a licensed nurse;

(g) Services required for terminal care.

e. In addition, the long-stay acute care hospital must provide for the educational and habilitative needs of the child. These services must be age appropriate, must meet state educational requirements, and must be appropriate to the child's cognitive level. Services must also be individualized to meet the child's specific needs and must be provided in an organized manner that encourages the child's participation. Services may include, but are not limited to, school, active treatment for mental retardation, habilitative therapies, social skills, and leisure activities. Therapeutic leisure activities must be provided daily.

f. Utilization review shall be performed to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

g. When the resident no longer meets long-stay hospital criteria or requires services that the facility is unable to provide, the resident must be discharged.

C. Nursing facilities.

1. Long-term care of residents in nursing facilities will

be provided in accordance with federal law using practices and procedures that are based on the resident's medical and social needs and requirements.

2. Nursing facilities must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. This assessment must be conducted no later than 14 days after the date of admission and promptly after a significant change in the resident's physical or mental condition. Each resident must be reviewed at least quarterly, and a complete assessment conducted at least annually.

3. The Department of Medical Assistance Services shall conduct at least annually a validation survey of the assessments completed by nursing facilities to determine that services provided to the residents are medically necessary and that needed services are provided. The survey will be composed of a sample of Medicaid residents and will include review of both current and closed medical records.

4. Nursing facilities must submit to the Department of Medical Assistance Services resident assessment information at least every six months for utilization review. If an assessment completed by the nursing facility does not reflect accurately a resident's capability to perform activities of daily living and significant impairments in functional capacity, then reimbursement to nursing facilities may be adjusted during the next quarter's reimbursement review. Any individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement in a resident assessment is subject to civil money penalties.

5. In order for reimbursement to be made to the nursing facility for a recipient's care, the recipient must meet nursing facility criteria as described in Supplement 1 to Attachment 3.1-C, Part 1 (Nursing Facility Criteria).

In order for reimbursement to be made to the nursing facility for a recipient requiring specialized care, the recipient must meet specialized care criteria as described in Supplement 1 to Attachment 3.1-C, Part 2 (Adult Specialized Care Criteria) or Part 3 (Pediatric/Adolescent Specialized Care Criteria). Reimbursement for specialized care must be preauthorized by the Department of Medical Assistance Services. In addition, reimbursement to nursing facilities for residents requiring specialized care will only be made on a contractual basis. Further specialized care services requirements are set forth below.

In each case for which payment for nursing facility services is made under the State Plan, a physician must recommend at the time of admission or, if later, the time at which the individual applies for medical

assistance under the State Plan that the individual requires nursing facility care.

6. For nursing facilities, a physician must approve a recommendation that an individual be admitted to a facility. The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. At the option of the physician, required visits after the initial visit may alternate between personal visits by the physician and visits by a physician assistant or nurse practitioner.

7. When the resident no longer meets nursing facility criteria or requires services that the nursing facility is unable to provide, then the resident must be discharged.

8. Specialized care services.

a. Providers must be nursing facilities certified by the Division of Licensure and Certification, State Department of Health, and must have a current signed participation agreement with the Department of Medical Assistance Services to provide nursing facility care. Providers must agree to provide care to at least four residents who meet the specialized care criteria for children/adolescents or adults.

b. Providers must be able to provide the following specialized services to Medicaid specialized care recipients:

(1) Physician visits at least once weekly [*(after initial physician visit, subsequent visits may alternate between physician and physician assistant or nurse practitioner)*];

(2) Skilled nursing services by a registered nurse available 24 hours a day;

(3) Coordinated multidisciplinary team approach to meet the needs of the resident;

(4) For residents under age 21, provision for the educational and habilitative needs of the child;

(5) For residents under age 21 who require two of three rehabilitative services (physical therapy, occupational therapy, or speech-language pathology services), therapy services must be provided at a minimum of [*six sessions 90 minutes*] each day [*; 15 minutes per session*], five days per week;

(6) For residents over age 21 who require two of three rehabilitative services (physical therapy, occupational therapy, or speech-language pathology services), therapy services must be provided at a minimum of [*four sessions two hours*] per day [*; 30 minutes per session*], five days a week;

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- (7) Ancillary services related to a plan of care;
- (8) Respiratory therapy services by a board-certified therapist (for ventilator patients, these services must be available 24 hours per day);
- (9) Psychology services by a board-certified psychologist or by a *licensed clinical social worker under the direct supervision of a licensed clinical psychologist or a licensed psychologist clinical* related to a plan of care;
- (10) Necessary durable medical equipment and supplies as required by the plan of care;
- (11) Nutritional elements as required;
- (12) A plan to assure that specialized care residents have the same opportunity to participate in integrated nursing facility activities as other residents;
- (13) Nonemergency transportation;
- (14) Discharge planning;
- (15) Family or caregiver training; and
- (16) Infection control.

D. *Intermediate Care Facilities for the Mentally Retarded (FMR) (ICF/MR) and Institutions for Mental Disease (IMD).*

1. With respect to each Medicaid-eligible resident in an FMR ICF/MR or IMD in Virginia, a written plan of care must be developed prior to admission to or authorization of benefits in such facility, and a regular program of independent professional review (including a medical evaluation) shall be completed periodically for such services. The purpose of the review is to determine: the adequacy of the services available to meet his current health needs and promote his maximum physical well being; the necessity and desirability of his continued placement in the facility; and the feasibility of meeting his health care needs through alternative institutional or noninstitutional services. Long-term care of residents in such facilities will be provided in accordance with federal law that is based on the resident's medical and social needs and requirements.

2. With respect to each intermediate care FMR or IMD, periodic on-site inspections of the care being provided to each person receiving medical assistance, by one or more independent professional review teams (composed of a physician or registered nurse and other appropriate health and social service personnel), shall be conducted. The review shall include, with respect to each recipient, a determination of the adequacy of the services available to meet his current

health needs and promote his maximum physical well-being, the necessity and desirability of continued placement in the facility, and the feasibility of meeting his health care needs through alternative institutional or noninstitutional services. Full reports shall be made to the state agency by the review team of the findings of each inspection, together with any recommendations.

3. In order for reimbursement to be made to a facility for the mentally retarded, the resident must meet criteria for placement in such facility as described in Supplement 1, Part 4, to Attachment 3.1-C and the facility must provide active treatment for mental retardation.

4. In each case for which payment for nursing facility services for the mentally retarded or institution for mental disease services is made under the State Plan:

a. A physician must certify for each applicant or recipient that inpatient care is needed in a facility for the mentally retarded or an institution for mental disease. The certification must be made at the time of admission or, if an individual applies for assistance while in the facility, before the Medicaid agency authorizes payment; and

b. A physician, or physician assistant or nurse practitioner acting within the scope of the practice as defined by state law and under the supervision of a physician, must recertify for each applicant at least every 365 days that services are needed in a facility for the mentally retarded or institution for mental disease.

5. When a resident no longer meets criteria for facilities for the mentally retarded or an institution for mental disease or no longer requires active treatment in a facility for the mentally retarded, then the resident must be discharged.

E. Psychiatric services resulting from an EPSDT screening.

Consistent with the Omnibus Budget Reconciliation Act of 1989 § 6403 and § 4b to Attachment 3.1 A & B Supplement 1, psychiatric services shall be covered, based on their prior authorization of medical need, for individuals younger than 21 years of age when the need for such services has been identified in a screening as defined by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. The following utilization control requirements shall be met before preauthorization of payment for services can occur.

1. Definitions. The following words and terms, when used in the context of these regulations, shall have the following meaning, unless the context clearly indicates otherwise:

"Admission" means the provision of services that are medically necessary and appropriate, and there is a reasonable expectation the patient will remain at least overnight and occupy a bed.

"CFR" means the Code of Federal Regulations.

"Psychiatric services resulting from an EPSDT screening" means services rendered upon admission to a psychiatric hospital.

"DMHMRAS" means the Department of Mental Health, Mental Retardation and Substance Abuse Services.

"DMAS" means the Department of Medical Assistance Services.

"JCAHO" means Joint Commission on Accreditation of Hospitals.

"Medical necessity" means that the use of the hospital setting under the direction of a physician has been demonstrated to be necessary to provide such services in lieu of other treatment settings and the services can reasonably be expected to improve the recipient's condition or to prevent further regression so that the services will no longer be needed.

"VDH" means the Virginia Department of Health.

2. It shall be documented that treatment is medically necessary and that the necessity was identified as a result of an EPSDT screening. Required patient documentation shall include, but not be limited to, the following:

a. Copy of the screening report showing the identification of the need for further psychiatric diagnosis and possible treatment.

b. Copy of supporting diagnostic medical documentation showing the diagnosis that supports the treatment recommended.

c. For admission to a psychiatric hospital, for psychiatric services resulting from an EPSDT screening, certification of the need for services by an interdisciplinary team meeting the requirements of 42 CFR §§ 441.153 or 441.156 that:

(1) Ambulatory care resources available in the community do not meet the recipient's treatment needs;

(2) Proper treatment of the recipient's psychiatric condition requires admission to a psychiatric hospital under the direction of a physician; and

(3) The services can reasonably be expected to

improve the recipient's condition or prevent further regression so that the services will no longer be needed, consistent with 42 CFR § 441.152.

3. The absence of any of the above required documentation shall result in DMAS' denial of the requested preauthorization.

4. Providers of psychiatric services resulting from an EPSDT screening must:

a. Be a psychiatric hospital accredited by JCAHO;

b. Assure that services are provided under the direction of a physician;

c. Meet the requirements in 42 CFR Part 441 Subpart D;

d. Be enrolled in the Commonwealth's Medicaid program for the specific purpose of providing psychiatric services resulting from an EPSDT screening.

F. Home health services.

1. Home health services which meet the standards prescribed for participation under Title XVIII will be supplied.

2. Home health services shall be provided by a licensed home health agency on a part-time or intermittent basis to a homebound recipient in his place of residence. The place of residence shall not include a hospital or nursing facility. Home health services must be prescribed by a physician and be part of a written plan of care utilizing the Home Health Certification and Plan of Treatment forms which the physician shall review at least every 62 days.

3. Except in limited circumstances described in subdivision 4 below, to be eligible for home health services, the patient must be essentially homebound. The patient does not have to be bedridden. Essentially homebound shall mean:

a. The patient is unable to leave home without the assistance of others or the use of special equipment;

b. The patient has a mental or emotional problem which is manifested in part by refusal to leave the home environment or is of such a nature that it would not be considered safe for him to leave home unattended;

c. The patient is ordered by the physician to restrict activity due to a weakened condition following surgery or heart disease of such severity that stress and physical activity must be avoided;

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d. The patient has an active communicable disease and the physician quarantines the patient.

4. Under the following conditions, Medicaid will reimburse for home health services when a patient is not essentially homebound. When home health services are provided because of one of the following reasons, an explanation must be included on the Home Health Certification and Plan of Treatment forms:

a. When the combined cost of transportation and medical treatment exceeds the cost of a home health services visit;

b. When the patient cannot be depended upon to go to a physician or clinic for required treatment, and, as a result, the patient would in all probability have to be admitted to a hospital or nursing facility because of complications arising from the lack of treatment;

c. When the visits are for a type of instruction to the patient which can better be accomplished in the home setting;

d. When the duration of the treatment is such that rendering it outside the home is not practical.

5. Covered services. Any one of the following services may be offered as the sole home health service and shall not be contingent upon the provision of another service.

a. Nursing services,

b. Home health aide services,

c. Physical therapy services,

d. Occupational therapy services,

e. Speech-language pathology services, or

f. Medical supplies, equipment, and appliances suitable for use in the home.

6. General conditions. The following general conditions apply to reimbursable home health services.

a. The patient must be under the care of a physician who is legally authorized to practice and who is acting within the scope of his or her license. The physician may be the patient's private physician or a physician on the staff of the home health agency or a physician working under an arrangement with the institution which is the patient's residence or, if the agency is hospital-based, a physician on the hospital or agency staff.

b. Services shall be furnished under a written plan

of care and must be established and periodically reviewed by a physician. The requested services or items must be necessary to carry out the plan of care and must be related to the patient's condition. The written plan of care shall appear on the Home Health Certification and Plan of Treatment forms.

c. A physician recertification shall be required at intervals of at least once every 62 days, must be signed and dated by the physician who reviews the plan of care, and should be obtained when the plan of care is reviewed. The physician recertification statement must indicate the continuing need for services and should estimate how long home health services will be needed. Recertifications must appear on the Home Health Certification and Plan of Treatment forms.

d. The physician orders for therapy services shall include the specific procedures and modalities to be used, identify the specific discipline to carry out the plan of care, and indicate the frequency and duration for services.

e. The physician orders for durable medical equipment and supplies shall include the specific item identification including all modifications, the number of supplies needed monthly, and an estimate of how long the recipient will require the use of the equipment or supplies. All durable medical equipment or supplies requested must be directly related to the physician's plan of care and to the patient's condition.

f. A written physician's statement located in the medical record must certify that:

(1) The home health services are required because the individual is confined to his or her home (except when receiving outpatient services);

(2) The patient needs licensed nursing care, home health aide services, physical or occupational therapy, speech-language pathology services, or durable medical equipment and/or supplies;

(3) A plan for furnishing such services to the individual has been established and is periodically reviewed by a physician; and

(4) These services were furnished while the individual was under the care of a physician.

g. The plan of care shall contain at least the following information:

(1) Diagnosis and prognosis,

(2) Functional limitations,

(3) Orders for nursing or other therapeutic services,

(4) Orders for medical supplies and equipment, when applicable

(5) Orders for home health aide services, when applicable,

(6) Orders for medications and treatments, when applicable,

(7) Orders for special dietary or nutritional needs, when applicable, and

(8) Orders for medical tests, when applicable, including laboratory tests and x-rays

6. Utilization review shall be performed by DMAS to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in patients' medical records as having been rendered shall be deemed not to have been rendered and no reimbursement shall be provided.

7. All services furnished by a home health agency, whether provided directly by the agency or under arrangements with others, must be performed by appropriately qualified personnel. The following criteria shall apply to the provision of home health services:

a. Nursing services. Nursing services must be provided by a registered nurse or by a licensed practical nurse under the supervision of a graduate of an approved school of professional nursing and who is licensed as a registered nurse.

b. Home health aide services. Home health aides must meet the qualifications specified for home health aides by 42 CFR 484.36. Home health aide services may include assisting with personal hygiene, meal preparation and feeding, walking, and taking and recording blood pressure, pulse, and respiration. Home health aide services must be provided under the general supervision of a registered nurse. A recipient may not receive duplicative home health aide and personal care aide services.

c. Rehabilitation services. Services shall be specific and provide effective treatment for patients' conditions in accordance with accepted standards of medical practice. The amount, frequency, and duration of the services shall be reasonable. Rehabilitative services shall be provided with the expectation, based on the assessment made by physicians of patients' rehabilitation potential, that the condition of patients will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with the specific diagnosis.

(1) Physical therapy services shall be directly and specifically related to an active written care plan designed by a physician after any needed consultation with a physical therapist licensed by the Board of Medicine. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a physical therapist licensed by the Board of Medicine, or a physical therapy assistant who is licensed by the Board of Medicine and is under the direct supervision of a physical therapist licensed by the Board of Medicine. When physical therapy services are provided by a qualified physical therapy assistant, such services shall be provided under the supervision of a qualified physical therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.

(2) Occupational therapy services shall be directly and specifically related to an active written care plan designed by a physician after any needed consultation with an occupational therapist registered and certified by the American Occupational Therapy Certification Board. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by an occupational therapist registered and certified by the American Occupational Therapy Certification Board, or an occupational therapy assistant who is certified by the American Occupational Therapy Certification Board under the direct supervision of an occupational therapist as defined above. When occupational therapy services are provided by a qualified occupational therapy assistant, such services shall be provided under the supervision of a qualified occupational therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.

(3) Speech-language pathology services shall be directly and specifically related to an active written care plan designed by a physician after any needed consultation with a speech-language pathologist licensed by the Board of Audiology and Speech-Language Pathology. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a speech-language pathologist licensed by the Board of Audiology and Speech-Language Pathology.

d. Durable medical equipment and supplies. Durable medical equipment, supplies, or appliances must be ordered by the physician, be related to the needs of the patient, and included on the plan of care. Treatment supplies used for treatment during the visit are included in the visit rate. Treatment supplies left in the home to maintain treatment after the visits shall be charged separately.

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e. A visit shall be defined as the duration of time that a nurse, home health aide, or rehabilitation therapist is with a client to provide services prescribed by a physician and that are covered home health services. Visits shall not be defined in measurements or increments of time.

G. Optometrists' services are limited to examinations (refractions) after preauthorization by the state agency except for eyeglasses as a result of an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

H. In the broad category of Special Services which includes nonemergency transportation, all such services for recipients will require preauthorization by a local health department.

I. Standards in other specialized high quality programs such as the program of Crippled Children's Services will be incorporated as appropriate.

J. Provisions will be made for obtaining recommended medical care and services regardless of geographic boundaries.

* * *

PART I.

INTENSIVE PHYSICAL REHABILITATIVE SERVICES.

§ 1.1. A patient qualifies for intensive inpatient or outpatient rehabilitation if:

A. Adequate treatment of his medical condition requires an intensive rehabilitation program consisting of a multi-disciplinary coordinated team approach to improve his ability to function as independently as possible; and

B. It has been established that the rehabilitation program cannot be safely and adequately carried out in a less intense setting.

§ 1.2. In addition to the initial disability requirement, participants shall meet the following criteria:

A. Require at least two of the listed therapies in addition to rehabilitative nursing:

1. Occupational Therapy
2. Physical Therapy
3. Cognitive Rehabilitation
4. Speech-Language Therapy

B. Medical condition stable and compatible with an active rehabilitation program.

PART II.

INPATIENT ADMISSION AUTHORIZATION.

§ 2.1. Within 72 hours of a patient's admission to an intensive rehabilitation program, or within 72 hours of notification to the facility of the patient's Medicaid eligibility, the facility shall notify the Department of Medical Assistance Services in writing of the patient's admission. This notification shall include a description of the admitting diagnoses, plan of treatment, expected progress and a physician's certification that the patient meets the admission criteria. The Department of Medical Assistance Services will make a determination as to the appropriateness of the admission for Medicaid payment and notify the facility of its decision. If payment is approved, the Department will establish and notify the facility of an approved length of stay. Additional lengths of stay shall be requested in writing and approved by the Department. Admissions or lengths of stay not authorized by the Department of Medical Assistance Services will not be approved for payment.

PART III.

DOCUMENTATION REQUIREMENTS.

§ 3.1. Documentation of rehabilitation services shall, at a minimum:

A. Describe the clinical signs and symptoms of the patient necessitating admission to the rehabilitation program;

B. Describe any prior treatment and attempts to rehabilitate the patient;

C. Document an accurate and complete chronological picture of the patient's clinical course and progress in treatment;

D. Document that a multi-disciplinary coordinated treatment plan specifically designed for the patient has been developed;

E. Document in detail all treatment rendered to the patient in accordance with the plan with specific attention to frequency, duration, modality, response to treatment, and identify who provided such treatment;

F. Document each change in each of the patient's conditions;

G. Describe responses to and the outcome of treatment; and

H. Describe a discharge plan which includes the anticipated improvements in functional levels, the time frames necessary to meet these goals, and the patient's discharge destination.

§ 3.2. Services not specifically documented in the patient's medical record as having been rendered will be deemed not to have been rendered and no reimbursement will be provided.

PART IV. INPATIENT REHABILITATION EVALUATION.

§ 4.1. For a patient with a potential for physical rehabilitation for which an outpatient assessment cannot be adequately performed, an intensive evaluation of no more than seven calendar days will be allowed. A comprehensive assessment will be made of the patient's medical condition, functional limitations, prognosis, possible need for corrective surgery, attitude toward rehabilitation, and the existence of any social problems affecting rehabilitation. After these assessments have been made, the physician, in consultation with the rehabilitation team, shall determine and justify the level of care required to achieve the stated goals.

§ 4.2. If during a previous hospital stay an individual completed a rehabilitation program for essentially the same condition for which inpatient hospital care is now being considered, reimbursement for the evaluation will not be covered unless there is a justifiable intervening circumstance which necessitates a re-evaluation.

§ 4.3. Admissions for evaluation and/or training for solely vocational or educational purposes or for developmental or behavioral assessments are not covered services.

PART V. CONTINUING EVALUATION.

§ 5.1. Team conferences shall be held as needed but at least every two weeks to assess and document the patient's progress or problems impeding progress. The team shall periodically assess the validity of the rehabilitation goals established at the time of the initial evaluation, and make appropriate adjustments in the rehabilitation goals and the prescribed treatment program. A review by the various team members of each others' notes does not constitute a team conference. A summary of the conferences, noting the team members present, shall be recorded in the clinical record and reflect the reassessments of the various contributors.

§ 5.2. Rehabilitation care is to be terminated, regardless of the approved length of stay, when further progress toward the established rehabilitation goal is unlikely or further rehabilitation can be achieved in a less intensive setting.

§ 5.3. Utilization review shall be performed to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no reimbursement shall be provided.

PART VI. THERAPEUTIC FURLOUGH DAYS.

§ 6.1. Properly documented medical reasons for furlough may be included as part of an overall rehabilitation

program. Unoccupied beds (or days) resulting from an overnight therapeutic furlough will not be reimbursed by the Department of Medical Assistance Services.

PART VII. DISCHARGE PLANNING.

§ 7.1. Discharge planning shall be an integral part of the overall treatment plan which is developed at the time of admission to the program. The plan shall identify the anticipated improvements in functional abilities and the probable discharge destination. The patient, unless unable to do so, or the responsible party shall participate in the discharge planning. Notations concerning changes in the discharge plan shall be entered into the record at least every two weeks, as a part of the team conference.

PART VIII. REHABILITATION SERVICES TO PATIENTS.

§ 8.1. Rehabilitation services are medically prescribed treatment for improving or restoring functions which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning. The rules pertaining to them are:

A. Rehabilitative nursing.

Rehabilitative nursing requires education, training, or experience that provides special knowledge and clinical skills to diagnose nursing needs and treat individuals who have health problems characterized by alteration in cognitive and functional ability.

Rehabilitative nursing are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan approved by a physician after any needed consultation with a registered nurse who is experienced in rehabilitation;
2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a registered nurse or licensed professional nurse, nursing assistant, or rehabilitation technician under the direct supervision of a registered nurse who is experienced in rehabilitation;
3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

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4. The service shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice and include the intensity of rehabilitative nursing services which can only be provided in an intensive rehabilitation setting.

B. Physical therapy.

Physical therapy services are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a physical therapist licensed by the Board of Medicine;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a physical therapist licensed by the Board of Medicine, or a physical therapy assistant who is licensed by the Board of Medicine and under the direct supervision of a qualified physical therapist licensed by the Board of Medicine;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

C. Occupational therapy.

Occupational therapy services are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by the physician after any needed consultation with an occupational therapist registered and certified by the American Occupational Therapy Certification Board;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature, that the services can only be performed by an occupational therapist registered and certified by the American Occupational Therapy Certification Board or an occupational therapy assistant certified by the American Occupational Therapy Certification Board under the direct supervision of a qualified

occupational therapist as defined above;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

D. Speech-language therapy.

Speech-language therapy services are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a speech-language pathologist licensed by the Board of Audiology and Speech-Language Pathology;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a speech-language pathologist licensed by the Board of Audiology and Speech-Language Pathology;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

E. Cognitive rehabilitation.

Cognitive rehabilitation services are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by the physician after any needed consultation with a clinical psychologist experienced in working with the neurologically impaired and licensed by the Board of

Medicine;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature, that the services can only be rendered after a neuropsychological evaluation administered by a clinical psychologist or physician experienced in the administration of neuropsychological assessments and licensed by the Board of Medicine and in accordance with a plan of care based on the findings of the neuropsychological evaluation;

3. Cognitive rehabilitation therapy services may be provided by occupational therapists, speech-language pathologists, and psychologists who have experience in working with the neurologically impaired when provided under a plan recommended and coordinated by a physician or clinical psychologist licensed by the Board of Medicine;

4. The cognitive rehabilitation services shall be an integrated part of the total patient care plan and shall relate to information processing deficits which are a consequence of and related to a neurologic event;

5. The services include activities to improve a variety of cognitive functions such as orientation, attention/concentration, reasoning, memory, discrimination and behavior; and

6. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis.

F. Psychology.

Psychology services are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan ordered by a physician;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a qualified psychologist as required by state law *or by a licensed clinical social worker under the direct supervision of a licensed clinical psychologist or a licensed psychologist clinical* ;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be

necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

G. Social work.

Social work services are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan ordered by a physician;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a qualified social worker as required by state law;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

H. Recreational therapy.

Recreational therapy are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan ordered by a physician;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services are performed as an integrated part of a comprehensive rehabilitation plan of care by a recreation therapist certified with the National Council for Therapeutic Recreation at the professional level;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be

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necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

I. Prosthetic/orthotic services.

1. Prosthetic services furnished to a patient include prosthetic devices that replace all or part of an external body member, and services necessary to design the device, including measuring, fitting, and instructing the patient in its use;

2. Orthotic device services furnished to a patient include orthotic devices that support or align extremities to prevent or correct deformities, or to improve functioning, and services necessary to design the device, including measuring, fitting and instructing the patient in its use; and

3. Maxillofacial prosthetic and related dental services are those services that are specifically related to the improvement of oral function not to include routine oral and dental care.

4. The services shall be directly and specifically related to an active written treatment plan approved by a physician after consultation with a prosthetist, orthotist, or a licensed, board eligible prosthodontist, certified in Maxillofacial prosthetics.

5. The services shall be provided with the expectation, based on the assessment made by physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and predictable period of time, or shall be necessary to establish an improved functional state of maintenance.

6. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical and dental practice; this includes the requirement that the amount, frequency, and duration of the services be reasonable.

J. Durable medical equipment.

1. Durable medical equipment furnished the patient receiving approved covered rehabilitation services is covered when the equipment is necessary to carry out an approved plan of rehabilitation. A rehabilitation hospital or a rehabilitation unit of a hospital enrolled with Medicaid under a separate provider agreement for rehabilitative services may supply the durable medical equipment. The provision of the equipment is

to be billed as an outpatient service. Medically necessary medical supplies, equipment and appliances shall be covered. Unusual amounts, types, and duration of usage must be authorized by DMAS in accordance with published policies and procedures. When determined to be cost-effective by DMAS, payment may be made for rental of the equipment in lieu of purchase. Payment shall not be made for additional equipment or supplies unless the extended provision of services has been authorized by DMAS. All durable medical equipment is subject to justification of need. Durable medical equipment normally supplied by the hospital for inpatient care is not covered by this provision.

2. Supplies, equipment, or appliances that are not covered for recipients of intensive physical rehabilitative services include, but are not limited to, the following:

a. Space conditioning equipment, such as room humidifiers, air cleaners, and air conditioners;

b. Durable medical equipment and supplies for any hospital or nursing facility resident, except ventilators and associated supplies for nursing facility residents that have been approved by DMAS central office;

c. Furniture or appliance not defined as medical equipment (such as blenders, bedside tables, mattresses other than for a hospital bed, pillows, blankets or other bedding, special reading lamps, chairs with special lift seats, hand-held shower devices, exercise bicycles, and bathroom scales);

d. Items that are only for the recipient's comfort and convenience or for the convenience of those caring for the recipient (e.g., a hospital bed or mattress because the recipient does not have a decent bed; wheelchair trays used as a desk surface; mobility items used in addition to primary assistive mobility aide for caregiver's or recipient's convenience, for example, an electric wheelchair plus a manual chair; cleansing wipes);

e. Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (for example, over-the-counter drugs; dentifrices; toilet articles; shampoos which do not require a physician's prescription; dental adhesives; electric toothbrushes; cosmetic items, soaps, and lotions which do not require a physician's prescription; sugar and salt substitutes; support stockings; and non-legend drugs);

f. Home or vehicle modifications;

g. Items not suitable for or used primarily in the home setting (i.e., but not limited to, car seats,

equipment to be used while at school);

h. Equipment that the primary function is vocationally or educationally related (i.e., but not limited to, computers, environmental control devices, speech devices) environmental control devices, speech devices).

PART IX. HOSPICE SERVICES.

§ 9.1. Admission criteria.

To be eligible for hospice coverage under Medicare or Medicaid, the individual must elect to receive hospice services rather than active treatment for the illness. Both the attending physician (if the individual has an attending physician) and the hospice medical director must certify the life expectancy.

§ 9.2. Utilization review.

Authorization for hospice services requires an initial preauthorization by DMAS and physician certification of life expectancy. Utilization review will be conducted to determine if services were provided by the appropriate provider and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the patients' medical records as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

§ 9.3. Hospice services are a medically directed, interdisciplinary program of palliative services for terminally ill people and their families, emphasizing pain and symptom control. The rules pertaining to them are:

1. Nursing care. Nursing care must be provided by a registered nurse or by a licensed practical nurse under the supervision of a graduate of an approved school of professional nursing and who is licensed as a registered nurse.

2. Medical social services. Medical social services must be provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.

3. Physician services. Physician services must be performed by a professional who is licensed to practice, who is acting within the scope of his license, and who is a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor. The hospice medical director or the physician member of the interdisciplinary team must be a licensed doctor of medicine or osteopathy.

4. Counseling services. Counseling services must be provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other caregiver to provide care, and for the purpose of helping the individual and those caring for him to adjust to the individual's approaching death. Bereavement counseling consists of counseling services provided to the individual's family up to one year after the individual's death. Bereavement counseling is a required hospice service, but it is not reimbursable.

5. Short-term inpatient care. Short-term inpatient care may be provided in a participating hospice inpatient unit, or a participating hospital or nursing facility. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home.

6. Durable medical equipment and supplies. Durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness is covered. Medical supplies include those that are part of the written plan of care.

7. Drugs and biologicals. Only drugs which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered.

8. Home health aide and homemaker services. Home health aides providing services to hospice recipients must meet the qualifications specified for home health aides by 42 CFR 484.36. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care. Home health aide and homemaker services must be provided under the general supervision of a registered nurse.

9. Rehabilitation services. Rehabilitation services include physical and occupational therapies and speech-language pathology services that are used for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

PART X. COMMUNITY MENTAL HEALTH SERVICES.

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§ 10.1. Utilization review general requirements.

A. On-site utilization reviews shall be conducted, at a minimum annually at each enrolled provider, by the state Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS). During each on-site review, an appropriate sample of the provider's total Medicaid population will be selected for review. An expanded review shall be conducted if an appropriate number of exceptions or problems are identified.

B. The DMHMRSAS review shall include the following items:

1. Medical or clinical necessity of the delivered service;
2. The admission to service and level of care was appropriate;
3. The services were provided by appropriately qualified individuals as defined in the Amount, Duration, and Scope of Services found in Attachment 3.1 A and B, Supplement 1 § 13d Rehabilitative Services; and
4. Delivered services as documented are consistent with recipients' Individual Service Plans, invoices submitted, and specified service limitations.

§ 10.2. Mental health services utilization criteria.

Utilization reviews shall include determinations that providers meet all the requirements of Virginia state regulations found at VR 460-03-3.1100.

A. Intensive in-home services for children and adolescents.

1. At admission, an appropriate assessment is made and documented that service needs can best be met through intervention provided typically but not solely in the client's residence; service shall be recommended in the Individual Service Plan (ISP) which shall be fully completed within 30 days of initiation of services.
2. Services shall be delivered primarily in the family's residence. Some services may be delivered while accompanying family members to community agencies or in other locations.
3. Services shall be used when out-of-home placement is a risk and when services that are far more intensive than outpatient clinic care are required to stabilize the family situation, and when the client's residence as the setting for services is more likely to be successful than a clinic.
4. Services are not appropriate for a family in which a child has run away or a family for which the goal

is to keep the family together only until an out-of-home placement can be arranged.

5. Services shall also be used to facilitate the transition to home from an out-of-home placement when services more intensive than outpatient clinic care are required for the transition to be successful.

6. At least one parent or responsible adult with whom the child is living must be willing to participate in in-home services, with the goal of keeping the child with the family.

7. The provider of intensive in-home services for children and adolescents shall be licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

8. The billing unit for intensive in-home service is one hour. Although the pattern of service delivery may vary, in-home service is an intensive service provided to individuals for whom there is a plan of care in effect which demonstrates the need for a minimum of five hours a week of intensive in-home service, and includes a plan for service provision of a minimum of five hours of service delivery per client/family per week in the initial phase of treatment. It is expected that the pattern of service provision may show more intensive services and more frequent contact with the client and family initially with a lessening or tapering off of intensity toward the latter weeks of service. Intensive in-home services below the five-hour a week minimum may be covered. However, variations in this pattern must be consistent with the individual service plan. Service plans must incorporate a discharge plan which identifies transition from intensive in-home to less intensive or nonhome based services.

9. The intensity of service dictates that caseload sizes should be six or fewer cases at any given time. If on review caseloads exceed this limit, the provider will be required to submit a corrective action plan designed to reduce caseload size to the required limit unless the provider can demonstrate that enough of the cases in the caseload are moving toward discharge so that the caseload standard will be met within three months by attrition. Failure to maintain required caseload sizes in two or more review periods may result in termination of the provider agreement unless the provider demonstrates the ability to attain and maintain the required caseload size.

10. Emergency assistance shall be available 24 hours per day, seven days a week.

B. Therapeutic day treatment for children and adolescents.

1. Therapeutic day treatment is appropriate for children and adolescents who meet the DMHMRSAS definitions of "serious emotional disturbance" or "a

risk of developing serious emotional disturbance" and who also meet one of the following:

a. Children and adolescents who require year-round treatment in order to sustain behavioral or emotional gains.

b. Children and adolescents whose behavior and emotional problems are so severe they cannot be handled in self-contained or resource emotionally disturbed (ED) classrooms without:

(1) This programming during the school day; or

(2) This programming to supplement the school day or school year.

c. Children and adolescents who would otherwise be placed on homebound instruction because of severe emotional/behavior problems that interfere with learning.

d. Children and adolescents who have deficits in social skills, peer relations, dealing with authority; are hyperactive; have poor impulse control; are extremely depressed or marginally connected with reality.

e. Children in preschool enrichment and early intervention programs when the children's emotional/behavioral problems are so severe that they cannot function in these programs without additional services.

2. The provider of therapeutic day treatment for child and adolescent services shall be licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

3. The minimum staff-to-youth ratio shall ensure that adequate staff is available to meet the needs of the youth identified on the ISP.

4. The program shall operate a minimum of two hours per day and may offer flexible program hours (i.e. before or after school or during the summer). One unit of service is defined as a minimum of two hours but less than three hours in a given day. Two units of service are defined as a minimum of three but less than five hours in a given day; and three units of service equals five or more hours of service. Transportation time to and from the program site may be included as part of the reimbursable unit. However, transportation time exceeding 25% of the total daily time spent in the service for each individual shall not be billable. These restrictions apply only to transportation to and from the program site. Other program-related transportation may be included in the program day as indicated by scheduled activities.

5. Time for academic instruction when no treatment

activity is going on cannot be included in the billing unit.

6. Services shall be provided following a diagnostic assessment when authorized by the physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker or certified psychiatric nurse and in accordance with an ISP which shall be fully completed within 30 days of initiation of the service.

C. Day treatment/partial hospitalization services shall be provided to adults with serious mental illness following diagnostic assessment when authorized by the physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, or certified psychiatric nurse, and in accordance with an ISP which shall be fully completed within 30 days of service initiation.

1. The provider of day treatment/partial hospitalization shall be licensed by DMHMRSAS.

2. The program shall operate a minimum of two continuous hours in a 24-hour period. One unit of service shall be defined as a minimum of two but less than four hours on a given day. Two units of service shall be defined as at least four but less than seven hours in a given day. Three units of service shall be defined as seven or more hours in a given day. Transportation time to and from the program site may be included as part of the reimbursable unit. However, transportation time exceeding 25% of the total daily time spent in the service for each individual shall not be covered. These restrictions shall apply only to transportation to and from the program site. Other program-related transportation may be included in the program day as indicated by scheduled program activities.

3. Individuals shall be discharged from this service when they are no longer in an acute psychiatric state or when other less intensive services may achieve stabilization. Admission and services longer than 90 calendar days must be authorized based upon a face-to-face evaluation by a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, or certified psychiatric nurse.

D. Psychosocial rehabilitation services shall be provided to those individuals who have mental illness or mental retardation, and who have experienced long-term or repeated psychiatric hospitalization, or who lack daily living skills and interpersonal skills, or whose support system is limited or nonexistent, or who are unable to function in the community without intensive intervention or when long-term care is needed to maintain the individual in the community.

1. Services shall be provided following an assessment which clearly documents the need for services and in

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accordance with an ISP which shall be fully completed within 30 days of service initiation.

2. The provider of psychosocial rehabilitation shall be licensed by DMHMRSAS.

3. The program shall operate a minimum of two continuous hours in a 24-hour period. One unit of service is defined as a minimum of two but less than four hours on a given day. Two units are defined as at least four but less than seven hours in a given day. Three units of service shall be defined as seven or more hours in a given day. Transportation time to and from the program site may be included as part of the reimbursement unit. However, transportation time exceeding 25% of the total daily time spent in the service for each individual shall not be covered. These restrictions apply only to transportation to and from the program site. Other program-related transportation may be included in the program day as indicated by scheduled program activities.

4. Time allocated for field trips may be used to calculate time and units if the goal is to provide training in an integrated setting, and to increase the client's understanding or ability to access community resources.

E. Admission to crisis intervention services is indicated following a marked reduction in the individual's psychiatric, adaptive or behavioral functioning or an extreme increase in personal distress. Crisis intervention may be the initial contact with a client.

1. The provider of crisis intervention services shall be licensed as an Outpatient Program by DMHMRSAS.

2. Client-related activities provided in association with a face-to-face contact are reimbursable.

3. An Individual Service Plan (ISP) shall not be required for newly admitted individuals to receive this service. Inclusion of crisis intervention as a service on the ISP shall not be required for the service to be provided on an emergency basis.

4. For individuals receiving scheduled, short-term counseling as part of the crisis intervention service, an ISP must be developed or revised to reflect the short-term counseling goals by the fourth face-to-face contact.

5. Reimbursement shall be provided for short-term crisis counseling contacts occurring within a 30-day period from the time of the first face-to-face crisis contact. Other than the annual service limits, there are no restrictions (regarding number of contacts or a given time period to be covered) for reimbursement for unscheduled crisis contacts.

6. Crisis intervention services may be provided to

eligible individuals outside of the clinic and billed, provided the provision of out-of-clinic services is clinically/programmatically appropriate. When travel is required to provide out-of-clinic services, such time is reimbursable. Crisis intervention may involve the family or significant others.

F. Case management.

1. Reimbursement shall be provided only for "active" case management clients, as defined. An active client for case management shall mean an individual for whom there is a plan of care in effect which requires regular direct or client-related contacts or activity or communication with the client or families, significant others, service providers, and others including a minimum of one face-to-face client contact within a 90-day period. Billing can be submitted only for months in which direct or client-related contacts, activity or communications occur.

2. The Medicaid eligible individual shall meet the DMHMRSAS criteria of serious mental illness, serious emotional disturbance in children and adolescents, or youth at risk of serious emotional disturbance.

3. There shall be no maximum service limits for case management services.

4. The ISP must document the need for case management and be fully completed within 30 days of initiation of the service, and the case manager shall review the ISP every three months. The review will be due by the last day of the third month following the month in which the last review was completed. A grace period will be granted up to the last day of the fourth month following the month of the last review. When the review was completed in a grace period, the next subsequent review shall be scheduled three months from the month the review was due and not the date of actual review.

5. The ISP shall be updated at least annually.

§ 10.3. Mental retardation utilization criteria.

Utilization reviews shall include determinations that providers meet all the requirements of Virginia state regulations found at VR 460-03-3.1100.

A. Appropriate use of day health and rehabilitation services requires the following conditions shall be met:

1. The service is provided by a program with an operational focus on skills development, social learning and interaction, support, and supervision.

2. The individual shall be assessed and deficits must be found in two or more of the following areas to qualify for services:

- a. Managing personal care needs,
 - b. Understanding verbal commands and communicating needs and wants,
 - c. Earning wages without intensive, frequent and ongoing supervision or support,
 - d. Learning new skills without planned and consistent or specialized training and applying skills learned in a training situation to other environments,
 - e. Exhibiting behavior appropriate to time, place and situation that is not threatening or harmful to the health or safety of self or others without direct supervision,
 - f. Making decisions which require informed consent,
 - g. Caring for other needs without the assistance or personnel trained to teach functional skills,
 - h. Functioning in community and integrated environments without structured, intensive and frequent assistance, supervision or support.
3. Services for the individual shall be preauthorized annually by DMHMRSAS.
 4. Each individual shall have a written plan of care developed by the provider which shall be fully complete within 30 days of initiation of the service, with a review of the plan of care at least every 90 days with modification as appropriate. A 10-day grace period is allowable.
 5. The provider shall update the plan of care at least annually.
 6. The individual's record shall contain adequate documentation concerning progress or lack thereof in meeting plan of care goals.
 7. The program shall operate a minimum of two continuous hours in a 24-hour period. One unit of service shall be defined as a minimum of two but less than four hours on a given day. Two units of service shall be at least four but less than seven hours on a given day. Three units of service shall be defined as seven or more hours in a given day. Transportation time to and from the program site may be included as part of the reimbursable unit. However, transportation time exceeding 25% of the total daily time spent in the service for each individual shall not be covered. These restrictions shall apply only to transportation to and from the program site. Other program-related transportation may be included in the program day as indicated by scheduled program activities.

8. The provider shall be licensed by DMHMRSAS.

B. Appropriate use of case management services for persons with mental retardation requires the following conditions to be met:

1. The individual must require case management as documented on the consumer service plan of care which is developed based on appropriate assessment and supporting data. Authorization for case management services shall be obtained from DMHMRSAS Care Coordination Unit annually.
2. An active client shall be defined as an individual for whom there is a plan of care in effect which requires regular direct or client-related contacts or communication or activity with the client, family, service providers, significant others and other entities including a minimum of one face-to-face contact within a 90-day period.
3. The plan of care shall address the individual's needs in all life areas with consideration of the individual's age, primary disability, level of functioning and other relevant factors.

a. The plan of care shall be reviewed by the case manager every three months to ensure the identified needs are met and the required services are provided. The review will be due by the last day of the third month following the month in which the last review was completed. A grace period will be given up to the last day of the fourth month following the month of the prior review. When the review was completed in a grace period, the next subsequent review shall be scheduled three months from the month the review was due and not the date of the actual review.

b. The need for case management services shall be assessed and justified through the development of an annual consumer service plan.

4. The individual's record shall contain adequate documentation concerning progress or lack thereof in meeting the consumer service plan goals.

PART XI. GENERAL OUTPATIENT PHYSICAL REHABILITATION SERVICES.

§ 11.1. Scope.

A. Medicaid covers general outpatient physical rehabilitative services provided in outpatient settings of acute and rehabilitation hospitals and by rehabilitation agencies which have a provider agreement with the Department of Medical Assistance Services (DMAS).

B. Outpatient rehabilitative services shall be prescribed by a physician and be part of a written plan of care.

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§ 11.2. Covered outpatient rehabilitative services.

Covered outpatient rehabilitative services shall include physical therapy, occupational therapy, and speech-language pathology services. Any one of these services may be offered as the sole rehabilitative service and shall not be contingent upon the provision of another service.

§ 11.3. Eligibility criteria for outpatient rehabilitative services.

To be eligible for general outpatient rehabilitative services, the patient must require at least one of the following services: physical therapy, occupational therapy, speech-language pathology services, and respiratory therapy. All rehabilitative services must be prescribed by a physician.

§ 11.4. Criteria for the provision of outpatient rehabilitative services.

All practitioners and providers of services shall be required to meet state and federal licensing and/or certification requirements.

A. Physical therapy services meeting all of the following conditions shall be furnished to patients:

1. Physical therapy services shall be directly and specifically related to an active written care plan designed by a physician after any needed consultation with a physical therapist licensed by the Board of Medicine.

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a physical therapist licensed by the Board of Medicine, or a physical therapy assistant who is licensed by the Board of Medicine and is under the direct supervision of a physical therapist licensed by the Board of Medicine. When physical therapy services are provided by a qualified physical therapy assistant, such services shall be provided under the supervision of a qualified physical therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

B. Occupational therapy services shall be those services furnished a patient which meet all of the following conditions:

1. Occupational therapy services shall be directly and specifically related to an active written care plan

designed by a physician after any needed consultation with an occupational therapist registered and certified by the American Occupational Therapy Certification Board.

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by an occupational therapist registered and certified by the American Occupational Therapy Certification Board, a graduate of a program approved by the Council on Medical Education of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association when under the supervision of an occupational therapist defined above, or an occupational therapy assistant who is certified by the American Occupational Therapy Certification Board under the direct supervision of an occupational therapist as defined above. When occupational therapy services are provided by a qualified occupational therapy assistant or a graduate engaged in supplemental clinical experience required before registration, such services shall be provided under the supervision of a qualified occupational therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

C. Speech-language pathology services shall be those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a speech-language pathologist licensed by the Board of Audiology and Speech-Language Pathology, or, if exempted from licensure by statute, meeting the requirements in 42 CFR 440.110(c);

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by or under the direction of a speech-language pathologist who meets the qualifications in subdivision B1 above. The program must meet the requirements of 42 CFR 405.1719(c). At least one qualified speech-language pathologist must be present at all times when speech-language pathology services are rendered; and

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this

includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

§ 11.5. Authorization for services.

A. ~~General physical rehabilitative~~ *Physical therapy, occupational therapy, and speech-language pathology* services provided in outpatient settings of acute and rehabilitation hospitals, ~~and by rehabilitation agencies, home health service agencies, or school divisions~~ shall include authorization for up to 24 visits by each ordered rehabilitative service ~~within a 60-day period annually~~. A recipient may receive a maximum of 48 visits annually ~~without authorization~~. The provider shall maintain documentation to justify the need for services. A visit shall be defined as the duration of time that a rehabilitative therapist is with a client to provide services prescribed by the physician. Visits shall not be defined in measurements or increments of time.

B. The provider shall request from DMAS authorization for treatments deemed necessary by a physician beyond the number authorized by ~~using the Rehabilitation Treatment Authorization form (DMAS-125)~~. This request ~~must be signed and dated by a physician~~. Documentation for medical justification must include physician orders or a plan of care signed by the physician. Authorization for extended services shall be based on individual need. Payment shall not be made for additional service unless the extended provision of services has been authorized by DMAS. Periods of care beyond those allowed which have not been authorized by DMAS shall not be approved for payment.

§ 11.6. Documentation requirements.

A. Documentation of general outpatient rehabilitative services provided by a hospital-based outpatient setting, home health agency, school division, or a rehabilitation agency shall, at a minimum:

1. describe the clinical signs and symptoms of the patient's condition;
2. include an accurate and complete chronological picture of the patient's clinical course and treatments;
3. document that a plan of care specifically designed for the patient has been developed based upon a comprehensive assessment of the patient's needs;
4. include a copy of the physician's orders and plan of care;
5. include all treatment rendered to the patient in accordance with the plan with specific attention to frequency, duration, modality, response, and identify who provided care (include full name and title);
6. describe changes in each patient's condition and response to the rehabilitative treatment plan; and

7. describe a discharge plan which includes the anticipated improvements in functional levels, the time frames necessary to meet these goals, and the patient's discharge destination.

B. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

§ 11.7. Service limitations.

The following general conditions shall apply to reimbursable physical rehabilitative services:

A. Patient must be under the care of a physician who is legally authorized to practice and who is acting within the scope of his license.

B. Services shall be furnished under a written plan of treatment and must be established and periodically reviewed by a physician. The requested services or items must be necessary to carry out the plan of treatment and must be related to the patient's condition.

C. A physician recertification shall be required periodically, must be signed and dated by the physician who reviews the plan of treatment, and may be obtained when the plan of treatment is reviewed. The physician recertification statement must indicate the continuing need for services and should estimate how long rehabilitative services will be needed.

D. The physician orders for therapy services shall include the specific procedures and modalities to be used, identify the specific discipline to carry out the plan of care, and indicate the frequency and duration for services.

E. Utilization review shall be performed to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

F. Rehabilitation care is to be terminated regardless of the approved length of stay when further progress toward the established rehabilitation goal is unlikely or when the services can be provided by someone other than the skilled rehabilitation professional.

PART XII. UTILIZATION REVIEW OF CASE MANAGEMENT FOR RECIPIENTS OF AUXILIARY GRANTS.

§ 12.1. Criteria of need for case management services.

It shall be the responsibility of the assessor who identifies the individual's need for residential or assisted living in an adult care residence to assess the need for

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case management services. The case manager shall, at a minimum, update the assessment and make any necessary referrals for service as part of the case management annual visit. Case management services may be initiated at any time during the year that a need is identified.

§ 12.2. Coverage limits.

DMAS shall reimburse for one case management visit per year for every individual who receives an auxiliary grant. For individuals meeting the following ongoing case management criteria, DMAS shall reimburse for one case management visit per calendar quarter:

1. The individual needs the coordination of multiple services and the individual does not currently have support available that is willing to assist in the coordination of and access to services, and a referral to a formal or informal support system will not meet the individual's needs; or
2. The individual has an identified need in his physical environment, support system, financial resources, emotional or physical health which must be addressed to ensure the individual's health and welfare and other formal or informal supports have either been unsuccessful in their efforts or are unavailable to assist the individual in resolving the need.

§ 12.3. Documentation requirements.

A. The update to the assessment shall be required annually regardless of whether the individual is authorized for ongoing case management.

B. A care plan and documentation of contacts must be maintained by the case manager for persons authorized for ongoing case management.

1. The care plan must be a standardized written description of the needs which cannot be met by the adult care residence and the resident-specific goals, objectives and time frames for completion. This care plan must be updated annually at the time of reassessment, including signature by both the resident and case manager.

2. The case manager shall provide ongoing monitoring and arrangement of services according to the care plan and must maintain documentation recording all contacts made with or on behalf of the resident.

VR 460-03-3.1301. Nursing Facility and MR Criteria.

§ 1. Nursing facility criteria introduction.

A. Traditionally, the model for nursing facility care has been facility or institutionally based; however, it is important to recognize that nursing facility care services can be delivered outside a nursing home. Nursing facility

care is the provision of services regardless of the specific setting. It is the care rather than the setting in which it is rendered that is significant. The criteria for assessing nursing facility care are divided into two areas: (i) functional capacity (the degree of assistance an individual requires to complete activities of daily living) and (ii) nursing needs.

B. The preadmission screening process marks the beginning of a continuum of long-term care services available to an individual under the Virginia Medical Assistance Program. Nursing facility care services are covered by the program for individuals whose needs meet the criteria established by program regulations.

C. Nursing facilities must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. This assessment must be conducted no later than 14 days after the date of admission and promptly after a significant change in the resident's physical or mental condition. The Department of Medical Assistance Services shall conduct a validation survey of the assessments completed by nursing facilities to determine that services provided to the residents are medically necessary and that needed services are provided.

D. The criteria for nursing facility care under the Virginia Medical Assistance Program are contained herein. An individual's need for care must meet this criteria before any authorization for payment by Medicaid will be made for either institutional or noninstitutional long-term care services. Reimbursement to nursing facilities for residents requiring specialized care shall only be made on a contractual basis.

§ 2. Criteria for nursing facility care.

A. Nursing facility care shall be the provision of services for persons whose health needs require medical and nursing supervision or care. These services may be provided in various settings, institutional and noninstitutional. Both the functional capacity of the individual and his nursing needs must be considered in determining the appropriateness of care.

B. Individuals may be considered appropriate for nursing facility care when one of the following describes their functional capacity:

1. Rated dependent in two to four of the Activities of Daily Living (Items 1-7), and also rated semi-dependent or dependent in Behavior Pattern and Orientation (Item 8), and semi-dependent in Medication Administration (Item 10).

2. Rated dependent in two to four of the Activities of Daily Living (Items 1-7), and also rated semi-dependent or dependent in Behavior Pattern and Orientation (Item 8), and semi-dependent in Joint Motion (Item 11).

3. Rated dependent in five to seven of the Activities of Daily Living (Items 1-7), and also rated dependent in Mobility (Item 9).

4. Rated semi-dependent in two to seven of the Activities of Daily Living (Items 1-7) and also rated dependent in Mobility (Item 9), and Behavior Pattern and Orientation (Item 8). An individual in this category will not be appropriate for nursing facility care unless he also has a medical condition requiring treatment or observation by a nurse.

C. Placement in a noninstitutional setting should be considered before nursing home placement is sought.

§ 3. Functional status.

The following abbreviations shall mean:

I = independent; d = semi-dependent; D = dependent; MH = mechanical help; HH = human help.

A. Bathing

1. Without help (I)
2. MH only (d)
3. HH only (D)
4. MH and HH (D)
5. Is bathed (D)

B. Dressing

1. Without help (I)
2. MH only (d)
3. HH only (D)
4. MH and HH (D)
5. Is dressed (D)
6. Is not dressed (D)

C. Toileting

1. Without help day and night (I)
2. MH only (d)
3. HH only (D)
4. MH and HH (D)
5. Does not use toilet room (D)

D. Transferring

1. Without help (I)
2. MH only (d)
3. HH only (D)
4. MH and HH (D)
5. Is transferred (D)
6. Is not transferred (D)

E. Bowel Function

1. Continent (I)
2. Incontinent less than weekly (d)
3. Ostomy - self care (d)
4. Incontinent weekly or more (D)
5. Ostomy - not self care (D)

F. Bladder Function

1. Continent (I)
2. Incontinent less than weekly (d)
3. External device - self care (d)
4. Indwelling catheter - self care (d)
5. Ostomy - self care (d)
6. Incontinent weekly or more (D)
7. External device - not self care (D)
8. Indwelling catheter - not self care (D)
9. Ostomy - not self care (D)

G. Eating/Feeding

1. Without help (I)
2. MH only (d)
3. HH only (D)
4. MH and HH (D)
5. Spoon fed (D)
6. Syringe or tube fed (D)
7. Fed by IV or elysis (D)

H. Behavior Pattern and Orientation

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1. Appropriate or Wandering/
Passive less than weekly + Oriented (I)
2. Appropriate or Wandering/
Passive less than weekly + Disoriented - Some
Spheres (I)
3. Wandering/Passive Weekly
or More + Oriented (I)
4. Appropriate or Wandering/
Passive less than weekly + Disoriented - All
Spheres (d)
5. Wandering/Passive Weekly
or more + Disoriented - Some or All Spheres (d)
6. Abusive/Aggressive/
Disruptive less than weekly + Oriented or
Disoriented (d)
7. Abusive/Aggressive/
Disruptive weekly or more + Oriented (d)
8. Abusive/Aggressive/
Disruptive weekly or more + Disoriented (D)
9. Mobility
 - a. Goes outside without help (I)
 - b. Goes outside MH only (d)
 - c. Goes outside HH only (D)
 - d. Goes outside MH and HH (D)
 - e. Confined - moves about (D)
 - f. Confined - does not move about (D)
10. Medication Administration
 - a. No medications (I)
 - b. Self administered - monitored less than weekly
(I)
 - c. By lay persons; monitored less than weekly (I)
 - d. By Licensed/Professional nurse and/or monitored
weekly or more (D)
 - e. Some or all by Professional nurse (D)
11. Joint Motion
 - a. Within normal limits (I)
 - b. Limited motion (d)

- c. Instability - corrected (I)
- d. Instability - uncorrected (D)
- e. Immobility (D)

§ 4. Nursing needs.

A. Following are examples of services provided or supervised by licensed nursing and professional personnel; however, no single service necessarily indicates a need for nursing facility care:

1. Application of aseptic dressings;
2. Routine catheter care;
3. Inhalation therapy after the regimen has been established;
4. Supervision for adequate nutrition and hydration for patients who, due to physical or mental impairments, are subject to malnourishment or dehydration;
5. Routine care in connection with plaster casts, braces, or similar devices;
6. Physical, occupational, speech, or other therapy;
7. Therapies, exercise and positioning to maintain or strengthen muscle tone, to prevent contractures, decubiti, and deterioration;
8. Routine care of colostomy or ileostomy;
9. Use of restraints including bedrails, soft binders, and wheelchair supports;
10. Routine skin care to prevent decubiti;
11. Care of small uncomplicated decubiti, and local skin rashes; or
12. Observation of those with sensory, metabolic, and circulatory impairment for potential medical complications.

B. Services requiring more intensive nursing care, such as wounds or lesions requiring daily care, nutritional deficiencies leading to specialized feeding, and paralysis or paresis benefitting from rehabilitation, shall be reimbursed at a higher rate.

C. The final determination for nursing facility care shall be based on the individual's need for medical and nursing management. Nursing facility care criteria are intended only as guidelines. Professional judgment must always be used to assure appropriateness of care.

§ 5. Specific services which do not meet the criteria for nursing facility care.

A. Care needs that do not meet the criteria for nursing facility care include, but are not limited to, the following:

1. Minimal assistance with activities of daily living;
2. Independent use of mechanical devices such as a wheelchair, walker, crutch, or cane;
3. Limited diets such as mechanically altered, low salt, low residue, diabetic, reducing, and other restrictive diets;
4. Medications that can be independently self-administered or administered by the individual with minimal supervision;
5. The protection of the patient to prevent him from obtaining alcohol or drugs, or from confronting an unpleasant situation; or
6. Minimal observation or assistance by staff for confusion, memory impairment, or poor judgment.

B. Special attention shall be given to individuals who receive psychiatric treatment. These individuals must also have care needs that meet the criteria for nursing facility care.

§ 6. Summary.

In patient placement, all available resources must be explored, i.e., the immediate family, other relatives, home health services, and other community resources. When applying the criteria, primary consideration is to be given to the utilization of available community/family resources.

§ 7. Adult specialized care criteria.

A. General description.

The resident must have long-term health conditions requiring close medical supervision, 24 hours licensed nursing care, and specialized services or equipment.

B. Targeted population.

1. Individuals requiring mechanical ventilation;
2. Individuals with communicable diseases requiring universal or respiratory precautions;
3. Individuals requiring ongoing intravenous medication or nutrition administration; or
4. Individuals requiring comprehensive rehabilitative therapy services.

C. Criteria:

1. The individual must require at a minimum:

a. Physician visits at least once weekly;

b. Skilled nursing services 24 hours a day (a registered nurse must be on the nursing unit on which the resident resides, 24 hours a day, whose sole responsibility is the designated unit); and

c. Coordinated multidisciplinary team approach to meet needs.

2. In addition, the individual must meet one of the following requirements:

a. Must require two out of three of the following rehabilitative services: Physical Therapy, Occupational Therapy, Speech-pathology services; therapy must be provided at a minimum of four therapy sessions (minimum of 30 minutes per session) per day, five days per week; individual must demonstrate progress in overall rehabilitative plan of care on a monthly basis; or

b. Must require special equipment such as mechanical ventilators, respiratory therapy equipment (that has to be supervised by licensed nurse or respiratory therapist), monitoring device (respiratory or cardiac), kinetic therapy; or

c. Individuals that require at least one of the following special services:

(1) Ongoing administration of intravenous medications or nutrition (i.e., TPN, antibiotic therapy, narcotic administration, etc.);

(2) Special infection control precautions (universal or respiratory precaution; this does not include handwashing precautions only);

(3) Dialysis treatment that is provided on-unit (i.e. peritoneal dialysis);

(4) Daily respiratory therapy treatments that must be provided by a skilled nurse or a respiratory therapist;

(5) Extensive wound care requiring debridement, irrigation, packing, etc., more than two times a day (i.e., grade IV decubiti; large surgical wounds that cannot be closed; second or third degree burns covering more than 10% of the body);

(6) Multiple unstable ostomies (a single ostomy does not constitute a requirement for special care) requiring frequent care (i.e. suctioning every hour; stabilization of feeding; stabilization of elimination, etc.);

§ 8. Pediatric/adolescent specialized care criteria.

A. General description.

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The child must have ongoing health conditions requiring close medical supervision; 24 hours licensed nursing supervision; and specialized services or equipment. The recipient must be age 21 or under.

B. Targeted population:

1. Children requiring mechanical ventilation;
2. Children with communicable diseases requiring universal or respiratory precautions (excluding normal childhood diseases such as chicken pox, measles, strep throat, etc.);
3. Children requiring ongoing intravenous medication or nutrition administration;
4. Children requiring daily dependence on device based respiratory or nutritional support (tracheostomy, gastrostomy, etc.);
5. Children requiring comprehensive rehabilitative therapy services;
6. Children with terminal illness.

B. Criteria:

1. The child must require at a minimum:

- a. Physician visits at least once weekly;
- b. Skilled nursing services 24 hours a day (a registered nurse must be on the nursing unit on which the child is residing; 24 hours a day; whose sole responsibility is that nursing unit);
- c. Coordinated multidisciplinary team approach to meet needs;
- d. The nursing facility must provide for the educational and habilitative needs of the child. These services must be age appropriate and appropriate to the cognitive level of the child. Services must also be individualized to meet the specific needs of the child and must be provided in an organized and proactive manner. Services may include but are not limited to school; active treatment for mental retardation; habilitative therapies; social skills and leisure activities. The services must be provided for a total of two hours per day, minimum.

2. In addition, the child must meet one of the following requirements:

- a. Must require two out of three of the following physical rehabilitative services: Physical therapy; Occupational therapy; Speech-pathology services; therapy must be provided at a minimum of six therapy sessions (minimum of 15 minutes per

session) per day; five days per week; child must demonstrate progress in overall rehabilitative plan of care on a monthly basis; or

- b. Must require special equipment such as mechanical ventilators; respiratory therapy equipment (that has to be supervised by licensed nurse or respiratory therapist); monitoring device (respiratory or cardiac); kinetic therapy, etc.; or

- c. Children that require at least one of the following special services:

(1) Ongoing administration of intravenous medications or nutrition (i.e., TPN; antibiotic therapy; narcotic administration, etc.);

(2) Special infection control precautions (universal or respiratory precaution; this does not include handwashing precautions only or isolation for normal childhood diseases such as measles; chicken pox; strep throat, etc.);

(3) Dialysis treatment that is provided within the facility (i.e., peritoneal dialysis);

(4) Daily respiratory therapy treatments that must be provided by a licensed nurse or a respiratory therapist;

(5) Extensive wound care requiring debridement; irrigation; packing, etc.; more than two times a day (i.e., grade IV decubiti; large surgical wounds that cannot be closed; second or third degree burns covering more than 10% of the body);

(6) Ostomy care requiring services by a licensed nurse;

(7) Care for terminal illness.

§ 9. Criteria for care in facilities for mentally retarded persons:

A. Definitions:

The following words and terms, when used in these criteria, shall have the following meaning, unless the context clearly indicates otherwise:

"No assistance" means no help is needed.

"Prompting/structuring" means prior to the functioning, some verbal direction or some rearrangement of the environment is needed.

"Supervision" means that a helper must be present during the function and provide only verbal direction; gestural prompts; or guidance.

"Some direct assistance" means that a helper must be

present and provide some physical guidance/support (with or without verbal direction).

"Total care" means that a helper must perform all or nearly all of the functions:

"Rarely" means that a behavior occurs quarterly or less:

"Sometimes" means that a behavior occurs once a month or less:

"Often" means that a behavior occurs two to three times a month:

"Regularly" means that a behavior occurs weekly or more:

B. Utilization control regulations require that criteria be formulated for guidance for appropriate levels of services. Traditionally, care for the mentally retarded has been institutionally based; however, this level of care need not be confined to a specific setting. The habilitative and health needs of the client are the determining issues.

C. The purpose of these regulations is to establish standard criteria to measure eligibility for Medicaid payment. Medicaid can pay for care only when the client is receiving appropriate services and when "active treatment" is being provided. An individual's need for care must meet these criteria before any authorization for payment by Medicaid will be made for either institutional or waived rehabilitative services for the mentally retarded.

D. Care in facilities for the mentally retarded requires planned programs for habilitative needs or health related services which exceed the level of room, board, and supervision of daily activities.

Such care shall be a combination of habilitative, rehabilitative, and health services directed toward increasing the functional capacity of the retarded person. Examples of services shall include training in the activities of daily living, task-learning skills, socially acceptable behaviors, basic community living programming, or health care and health maintenance. The overall objective of programming shall be the attainment of the optimal physical, intellectual, social, or task learning level which the person can presently or potentially achieve.

E. The evaluation and re-evaluation for care in a facility for the mentally retarded shall be based on the needs of the person, the reasonable expectations of the resident's capabilities, the appropriateness of programming, and whether progress is demonstrated from the training and, in an institution, whether the services could reasonably be provided in a less restrictive environment.

§ 10. Patient assessment criteria:

A. The patient assessment criteria are divided into broad

categories of needs, or services provided. These must be evaluated in detail to determine the abilities/skills which will be the basis for the development of a plan of care. The evaluation process will demonstrate a need for programming an array of skills and abilities or health care services. These have been organized into seven major categories. Level of functioning in each category is graded from the most dependent to the least dependent. In some categories, the dependency status is rated by the degree of assistance required. In other categories, the dependency is established by the frequency of a behavior or ability to perform a given task.

B. The resident must meet the indicated dependency level in two or more of categories 1 through 7:

1. Health Status - To meet this category:

a. Two or more questions must be answered with a 4, or

b. Question "j" must be answered "yes."

2. Communication Skills - To meet this category:

Three or more questions must be answered with a 3 or a 4.

3. Task Learning Skills - To meet this category:

Three or more questions must be answered with a 3 or a 4.

4. Personal Care - To meet this category:

a. Question "a" must be answered with a 4 or a 5, or

b. Question "b" must be answered with a 4 or a 5, or

c. Questions "c" and "d" must be answered with a 4 or a 5.

5. Mobility - To meet this category:

Any one question must be answered with a 4 or a 5.

6. Behavior - To meet this category:

Any one question must be answered with a 3 or a 4.

7. Community Living - To meet this category:

a. Any two of the questions "b," "c," or "g" must be answered with a 4 or a 5, or

b. Three or more questions must be answered with a 4 or a 5.

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LEVEL OF FUNCTIONING SURVEY

1. Health status:

How often is nursing care or nursing supervision by a licensed nurse required for the following? (Key: 1=Rarely, 2=Sometimes, 3=Often, and 4=Regularly)

- a. Medication administration and/or evaluation for effectiveness of a medication regimen? 1...2...3...4
- b. Direct services: i.e. care for lesions, dressings, treatments (other than shampoos, foot powder, etc.) 1...2...3...4
- c. Seizures control 1...2...3...4
- d. Teaching diagnosed disease control and care, including diabetes 1...2...3...4
- e. Management of care of diagnosed circulatory or respiratory problems 1...2...3...4
- f. Motor disabilities which interfere with all activities of Daily Living - Bathing, Dressing, Mobility, Toileting, etc. 1...2...3...4
- g. Observation for choking/aspiration while eating, drinking? 1...2...3...4
- h. Supervision of use of adaptive equipment, i.e., special spoon, braces, etc. 1...2...3...4
- i. Observation for nutritional problems (i.e., undernourishment, swallowing difficulties, obesity) 1...2...3...4
- j. Is age 55 or older, has a diagnosis of a chronic disease and has been in an institution 20 years or more 1...2...3...4

2. Communication:

Using the key 1=regularly, 2=often, 3=sometimes, 4=rarely, how often does this person

- a. Indicate wants by pointing, vocal noises, or signs? 1...2...3...4
- b. Use simple words, phrases, short sentences? 1...2...3...4
- c. Ask for at least ten things using appropriate names? 1...2...3...4
- d. Understand simple words, phrases or instructions containing prepositions: i.e., "on" "in" "behind"? 1...2...3...4
- e. Speak in an easily understood manner? 1...2...3...4

f. Identify self, place of residence, and significant others? 1...2...3...4

3. Task learning skills:

How often does this person perform the following activities (Key: 1=regularly, 2=often, 3=sometimes, 4=rarely)

- a. Pay attention to purposeful activities for 5 minutes? 1...2...3...4
- b. Stay with a 3 step task for more than 15 minutes? 1...2...3...4
- c. Tell time to the hour and understand time intervals? 1...2...3...4
- d. Count more than 10 objects? 1...2...3...4
- e. Do simple addition, subtraction? 1...2...3...4
- f. Write or print ten words? 1...2...3...4
- g. Discriminate shapes, sizes, or colors? 1...2...3...4
- h. Name people or objects when describing pictures? 1...2...3...4
- i. Discriminate between "one," "many," "lot"? 1...2...3...4

4. Personal/self care:

With what type of assistance can this person currently (Key: 1=No Assistance, 2=Prompting/Structuring, 3=Supervision, 4=Some Direct Assistance, 5=Total Care)

- a. Perform toileting functions: i.e., maintain bladder and bowel continence, clean self, etc.? 1...2...3...4...5
- b. Perform eating/feeding functions: i.e., drinks liquids and eats with spoon or fork, etc.? 1...2...3...4...5
- c. Perform bathing function (i.e., bathe, runs bath, dry self, etc.)? 1...2...3...4...5

5. Mobility:

With what type of assistance can this person currently (Key: 1=No Assistance, 2=Prompting/Structuring, 3=Supervision, 4=Some Direct Assistance, 5=Total Care)

- a. Move (walking, wheeling) around environment? 1...2...3...4...5
- b. Rise from lying down to sitting positions, sits without support? 1...2...3...4...5
- c. Turn and position in bed, roll over? 1...2...3...4...5

6. Behavior.

How often does this person (Key: 1=Rarely, 2=Sometimes, 3=Often, 4=Regularly)

- a. Engage in self destructive behavior? 1...2...3...4
- b. Threaten or do physical violence to others? 1...2...3...4
- c. Throw things, damage property, have temper outbursts? 1...2...3...4
- d. Respond to others in a socially unacceptable manner - (without undue anger, frustration or hostility) 1...2...3...4

7. Community living skills.

With what type of assistance would this person currently be able to (Key: 1=No Assistance, 2=Prompting/Structuring, 3=Supervision, 4=Some Direct Assistance, 5=Total Care)

- a. Prepare simple foods requiring no mixing or cooking? 1...2...3...4...5
- b. Take care of personal belongings, room (excluding vacuuming, ironing, clothes washing/drying, wet mopping)? 1...2...3...4...5
- c. Add coins of various denominations up to one dollar? 1...2...3...4...5
- d. Use the telephone to call home, doctor, fire, police? 1...2...3...4...5
- e. Recognize survival signs/words: i.e., stop, go, traffic lights, police, men, women, restrooms, danger, etc.? 1...2...3...4...5
- f. Refrain from exhibiting unacceptable sexual behavior in public? 1...2...3...4...5
- g. Go around cottage, ward, building, without running away, wandering off, or becoming lost? 1...2...3...4...5
- h. Make minor purchases i.e., candy, soft drink, etc.? 1...2...3...4...5

PART I. NURSING FACILITY CRITERIA.

§ 1.1. Introduction.

A. Medicaid-funded long-term care services may be provided in either a nursing facility or community-based care setting. The criteria for assessing an individual's eligibility for Medicaid payment of nursing facility care consist of two components: (i) functional capacity (the degree of assistance an individual requires to complete

activities of daily living) and (ii) medical or nursing needs. The criteria for assessing an individual's eligibility for Medicaid payment of community-based care consist of three components: (i) functional capacity (the degree of assistance an individual requires to complete activities of daily living); (ii) medical or nursing needs; and (iii) the individual's risk of nursing facility placement in the absence of community-based waiver services.

1. In order to qualify for Medicaid payment for nursing facility care an individual must meet both functional capacity requirements and have a medical condition which requires ongoing medical or nursing management. An exception may be made when the individual does not meet the functional capacity requirement but the individual does have a health condition that requires the daily direct services of a licensed nurse that cannot be managed on an outpatient basis.

2. In order to qualify for Medicaid payment for community-based care an individual must either meet both the functional and medical components of the nursing facility criteria or meet the prenursing facility criteria defined in § 2.3. In addition, the individual must be determined to be at risk of nursing facility placement unless services under the waiver are offered.

B. The preadmission screening process preauthorizes a continuum of long-term care services available to an individual under the Virginia Medical Assistance Program. Nursing facilities' preadmission screenings to authorize Medicaid-funded long-term care are performed by teams composed by agencies contracting with the Department of Medical Assistance Services (DMAS). The authorization for Medicaid-funded long-term care may be rescinded by the nursing facility or community-based care provider or by DMAS at any point that the individual is determined to no longer meet the criteria for Medicaid-funded long-term care. Medicaid-funded long-term care services are covered by the program for individuals whose needs meet the criteria established by program regulations. Authorization of appropriate noninstitutional services shall be evaluated before [*actual*] nursing facility placement is considered.

C. Prior to an individual's admission, the nursing facility must review the completed preadmission screening forms to ensure that appropriate nursing facility admission criteria have been documented. The nursing facility is also responsible for documenting, upon admission and on an ongoing basis, that the individual meets and continues to meet nursing facility criteria. For this purpose, the nursing facility will use the Minimum Data Set (MDS). The post admission assessment must be conducted no later than 14 days after the date of admission and promptly after a significant change in the resident's physical or mental condition. If at any time during the course of the resident's stay, it is determined that the resident does not meet nursing facility criteria as defined in the State Plan for Medical Assistance, the

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nursing facility must initiate discharge of such resident. Nursing facilities must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity and medical and nursing needs.

The Department of Medical Assistance Services shall conduct surveys of the assessments completed by nursing facilities to determine that services provided to the residents meet nursing facility criteria and that needed services are provided.

D. The community-based provider is responsible for documenting upon admission and on an ongoing basis that the individual meets the criteria for Medicaid-funded long-term care.

E. The criteria for nursing facility care under the Virginia Medical Assistance Program are contained herein. An individual's need for care must meet these criteria before any authorization for payment by Medicaid will be made for either institutional or noninstitutional long-term care services. The Nursing Home Preadmission Screening team is responsible for documenting on the state-designated assessment instrument that the individual meets the criteria for nursing facility or community-based waiver services and for authorizing admission to Medicaid funded long-term care. The rating of functional dependencies on the assessment instrument must be based on the individual's ability to function in a community environment, not including any institutionally induced dependence.

§ 1.2. Preadmission screening criteria for nursing facility care.

A. Functional dependency alone is not sufficient to demonstrate the need for nursing facility care or placement.

B. Except as provided for in § 1.1 A, an individual may only be considered to meet the nursing facility criteria when both the functional capacity of the individual and his medical or nursing needs meet the following requirements. Even when an individual meets nursing facility criteria, placement in a noninstitutional setting shall be evaluated before actual nursing facility placement is considered.

1. Functional capacity.

a. When documented on a completed state-designated preadmission screening assessment instrument which is completed in a manner consistent with the definitions of activities of daily living and directions provided by DMAS for the rating of those activities, individuals may be considered to meet the functional capacity requirements for nursing facility care when one of the following describes their functional capacity:

(1) Rated dependent in two to four of the Activities

of Daily Living, and also rated semi-dependent or dependent in Behavior Pattern and Orientation, and semi-dependent in Joint Motion or [semi] dependent in Medication Administration.

(2) Rated dependent in five to seven of the Activities of Daily Living, and also rated dependent in Mobility.

(3) Rated semi-dependent in two to seven of the Activities of Daily Living, and also rated dependent in Mobility and Behavior Pattern and Orientation.

b. The rating of functional dependencies on the preadmission screening assessment instrument must be based on the individual's ability to function in a community environment, not including any institutionally induced dependence. The following abbreviations shall mean: I = independent; d = semi-dependent; D = dependent; MH = mechanical help; HH = human help.

(1) Bathing

(a) Without help (I)

(b) MH only (d)

(c) HH only (D)

(d) MH and HH (D)

(e) [~~Is bathed~~ Performed by others] (D)

(2) Dressing

(a) Without help (I)

(b) MH only (d)

(c) HH only (D)

(d) MH and HH (D)

(e) [~~Is dressed~~ Performed by others] (D)

(f) [~~Is not dressed~~ Is not performed] (D)

(3) Toileting

(a) Without help day or night (I)

(b) MH only (d)

(c) HH only (D)

(d) MH and HH (D)

(e) [~~Does not use toilet room~~ Performed by others] (D)

[(f) Is not performed (D)]

(4) Transferring

(a) Without help (I)

(b) MH only (d)

(c) HH only (D)

(d) MH and HH (D)

(e) [~~Is transferred~~ Performed by others] (D)

(f) Is not [~~transferred~~ performed] (D)

(5) Bowel Function

(a) Continent (I)

(b) Incontinent less than weekly (d)

(c) [External/Indwelling Device/] Ostomy - self-care (d)

(d) Incontinent weekly or more (D)

(e) Ostomy - not self-care (D)

(6) Bladder Function

(a) Continent (I)

(b) Incontinent less than weekly (d)

(c) External device [/Indwelling catheter/Ostomy] self-care (d)

[(d) ~~Indwelling catheter~~ - self-care (d)

(e) ~~Ostomy~~ - self-care (d)]

[(f) (d)] Incontinent weekly or more (D)

[(g) (e)] External device - not self-care (D)

[(h) (f)] Indwelling catheter - not self-care (D)

[(i) (g)] Ostomy - not self-care (D)

(7) Eating/Feeding

(a) Without help (I)

(b) MH only (d)

(c) HH only (D)

(d) MH and HH (D)

(e) Spoon fed (D)

(f) Syringe or tube fed (D)

(g) Fed by IV or clysis (D)

(8) Behavior Pattern and Orientation

(a) Appropriate or Wandering/Passive less than weekly + Oriented (I)

(b) Appropriate or Wandering/Passive less than weekly + Disoriented - Some Spheres (I)

(c) Wandering/Passive Weekly/or more + Oriented (I)

(d) Appropriate or Wandering/Passive less than weekly + Disoriented - All Spheres (d)

(e) Wandering/Passive Weekly/Some or more + Disoriented - All Spheres (d)

(f) Abusive/Aggressive/Disruptive less than weekly + Oriented or Disoriented (d)

(g) Abusive/Aggressive/Disruptive weekly or more + Oriented (d)

(h) Abusive/Aggressive/Disruptive [~~weekly or more~~] + Disoriented [- All Spheres] (D)

(9) Mobility

(a) Goes outside without help (I)

(b) Goes outside MH only (d)

(c) Goes outside HH only (D)

(d) Goes outside MH and HH (D)

(e) Confined - moves about (D)

(f) Confined - does not move about (D)

(10) Medication Administration

(a) No medications (I)

(b) Self-administered - monitored less than weekly (I)

(c) By lay persons, [~~monitored less than weekly~~ (d) Administered/Monitored (D)]

(d) By Licensed/Professional nurse [~~and/or monitored weekly or more~~ (d) Administered/Monitored (D)]

[(e) ~~Some or all~~ by Professional nurse (D)]

(11) Joint Motion

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(a) *Within normal limits (I)*

(b) *Limited motion (d)*

[(e) *Instability - corrected (H)*]

[~~(d)~~ (c)] *Instability - uncorrected [or Immobile] (D)*

[(e) *Immobility (D)*]

2. An individual with medical or nursing needs is an individual whose health needs require medical or nursing supervision or care above the level which could be provided through assistance with Activities of Daily Living, Medication Administration and general supervision and is not primarily for the care and treatment of mental diseases. Medical or nursing supervision or care beyond this level is required when any one of the following describes the individual's need for medical or nursing supervision:

a. The individual's medical condition requires observation and assessment to assure evaluation of the person's need for modification of treatment or additional medical procedures to prevent destabilization and the person has demonstrated an inability to self-observe or evaluate the need to contact skilled medical professionals;

b. Due to the complexity created by the person's multiple, interrelated medical conditions, the potential for the individual's medical instability is high or medical instability exists; or

c. The individual requires at least one ongoing medical/nursing service. The following is a nonexclusive list of medical/nursing services which may, but need not necessarily, indicate a need for medical or nursing supervision or care:

(1) *Application of aseptic dressings;*

(2) *Routine catheter care;*

(3) *Respiratory therapy;*

(4) *Supervision for adequate nutrition and hydration for individuals who show clinical evidence of malnourishment or dehydration or have recent history of weight loss or inadequate hydration which, if not supervised would be expected to result in malnourishment or dehydration;*

(5) *Therapeutic exercise and positioning;*

(6) *Routine care of colostomy or ileostomy or management of neurogenic bowel and bladder;*

(7) *Use of physical (e.g., side rails, poseys, locked wards) or chemical restraints;*

(8) *Routine skin care to prevent pressure ulcers for individuals who are immobile;*

(9) *Care of small uncomplicated pressure ulcers, and local skin rashes;*

(10) *Management of those with sensory, metabolic, or circulatory impairment with demonstrated clinical evidence of medical instability;*

(11) *Chemotherapy;*

(12) *Radiation;*

(13) *Dialysis;*

(14) *Suctioning;*

(15) *Tracheostomy care;*

(16) *Infusion Therapy;*

(17) *Oxygen.*

3. Even when an individual meets nursing facility criteria, provision of services in a noninstitutional setting shall be considered before nursing facility placement is sought.

§ 1.3. Summary of preadmission nursing facility criteria.

A. An individual shall be determined to meet the nursing facility criteria when:

1. The individual has both limited functional capacity and requires medical or nursing management according to the requirements of § 2.1; or

2. The individual is rated dependent in some functional limitations, but does not meet the functional capacity requirements, and the individual requires the daily direct services or supervision of a licensed nurse that cannot be managed on an outpatient basis (e.g., clinic, physician visits, home health services).

B. An individual shall not be determined to meet nursing facility criteria when one of the following specific care needs solely describes his condition:

1. An individual who requires minimal assistance with activities of daily living, including those persons whose only need in all areas of functional capacity is for prompting to complete the activity;

2. An individual who independently uses mechanical devices such as a wheelchair, walker, crutch, or cane;

3. An individual who requires limited diets such as a mechanically altered, low salt, low residue, diabetic, reducing, and other restrictive diets;

4. An individual who requires medications that can be independently self-administered or administered by the caregiver;

5. An individual who requires protection to prevent him from obtaining alcohol or drugs or to address a social/environmental problem;

6. An individual who requires minimal staff observation or assistance for confusion, memory impairment, or poor judgment;

7. An individual whose primary need is for behavioral management which can be provided in a community-based setting;

§ 1.4. Evaluation to determine eligibility for Medicaid payment of nursing facility or home- and community-based care services.

A. The screening team shall not authorize Medicaid-funded nursing facility services for any individual who does not meet nursing facility criteria. Once the nursing home preadmission screening team has determined whether or not an individual meets the nursing facility criteria, the screening team must determine the most appropriate and cost-effective means of meeting the needs of the individual. The screening team must document a complete assessment of all the resources available for that individual in the community (i.e., the immediate family, other relatives, other community resources and other services in the continuum of long-term care which are less intensive than nursing facility level-of-care services). The screening team shall be responsible for preauthorizing Medicaid-funded long-term care according to the needs of each individual and the support required to meet those needs. The screening team shall authorize Medicaid-funded nursing facility care for an individual who meets the nursing facility criteria only when services in the community are either not a feasible alternative or the individual or the individual's representative rejects the screening team's plan for community services. The screening team must document that the option of community-based alternatives has been explained, the reason community-based services were not chosen, and have this document signed by the client or client's primary caregivers.

B. The screening team shall authorize community-based waiver services only for an individual who:

1. Meets the nursing facility criteria and is at risk of nursing home placement without waiver services. Waiver services are offered to such an individual as an alternative to avoid nursing facility admission; or

2. Meets the following prenursing facility criteria and is at risk of nursing home placement without waiver services. Waiver services are offered to such an individual as a preventive service to delay or avoid nursing facility admission which would be required in

the near future if community-based care is not offered. The prenursing facility criteria are:

a. The individual is rated dependent in four of the activities of daily living and also rated dependent in mobility and has a need for medical or nursing supervision, or

b. The individual meets the functional dependency component of the nursing facility criteria but lacks a medical or nursing need.

C. Federal regulations which govern Medicaid-funded home- and community-based services require that services only be offered to individuals who would otherwise require institutional placement in the absence of home- and community-based services. The determination that an individual would otherwise require placement in a nursing facility is based upon a finding that the individual's current condition and available support are insufficient to enable the individual to remain in the home and thus the individual is at risk of institutionalization if community-based care is not authorized. The determination of the individual's risk of nursing facility placement shall be documented either on the state-designated preadmission screening assessment or in a separate attachment for every individual authorized to receive community-based waiver services. To authorize community-based waiver services, the screening team must document that the individual is at risk of nursing facility placement by finding that one of the following conditions is met:

1. Application for the individual to a nursing facility has been made and accepted.

2. The individual has been cared for in the home prior to the assessment and evidence is available demonstrating a deterioration in the individual's health care condition or a change in available support preventing former care arrangements from meeting the individual's need. Examples of such evidence may be, but shall not necessarily be limited to:

a. Recent hospitalizations.

b. Attending physician documentation, or

c. Reported findings from medical or social service agencies.

3. There has been no change in condition or available support but evidence is available that demonstrates the individual's functional, medical and nursing needs are not being met. Examples of such evidence may be, but shall not necessarily be limited to:

a. Recent hospitalizations.

b. Attending physician documentation, or

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c. Reported findings from medical or social service agencies.

§ 1.5. Criteria for continued nursing facility care using the Minimum Data Set (MDS).

Individuals may be considered appropriate for nursing facility care when one of the following describes their medical or nursing needs and functional capacity as recorded on the Minimum Data Set (MDS) of the Resident Assessment Instrument that is specified by the Commonwealth:

1. Functional capacity:

a. The individual meets criteria for two to four of the Activities of Daily Living, plus Behavior and Orientation, and Joint Motion;

b. The individual meets criteria for five to seven of the Activities of Daily Living and also for Locomotion; or

c. The individual meets criteria for two to seven of the Activities of Daily Living and also for Locomotion, and Behavior and Orientation. An individual in this category will not be appropriate for nursing facility care unless he also has a medical condition requiring treatment or observation by a nurse.

2. Medical or nursing needs. The individual has health needs which require medical or nursing supervision or care above the level which could be provided through assistance with activities of daily living, medication administration and general supervision and is not primarily for the care and treatment of mental diseases.

§ 1.6. Definitions to be applied when completing the MDS.

A. Activities of Daily Living (ADLs):

1. Transfer (§ E(1)(b)). In order to meet this ADL, the individual must score a 1, 2, 3, 4, or 8 as described below:

a. (0) Independent - No help or oversight - OR - help/oversight provided only 1 or 2 times during last 7 days

b. (1) Supervision - Oversight, encouragement or cueing provided 3+ times during last 7 days - OR - supervision plus physical assistance provided on 1 or 2 times during last 7 days

c. (2) Limited assistance - Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3+ times - OR - more help provided only 1 or 2 times during last 7 days

d. (3) Extensive assistance - While resident performed part of activity, over last 7-day period, help of following type or types was provided 3 or more times: weight-bearing support or full staff performance during part (but not all) of last 7 days

e. (4) Total dependence - Full staff performance of activity during entire 7 days

f. (8) Activity did not occur during the entire 7-day period. Use of this code is limited to situations where the ADL activity was not performed and is primarily applicable to fully bed bound residents who neither transferred from bed nor moved between locations over the entire 7-day period.

2. Dressing (§ E(1)(d)). In order to meet this ADL, the individual must score a 1, 2, 3, 4, or 8 as described below:

a. (0) Independent - No help or oversight - OR - help/oversight provided only 1 or 2 times during last 7 days

b. (1) Supervision - Oversight, encouragement or cueing provided 3+ times during last 7 days - OR - supervision plus physical assistance provided on 1 or 2 times during last 7 days

c. (2) Limited assistance - Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3+ times - OR - more help provided only 1 or 2 times during last 7 days

d. (3) Extensive assistance - While resident performed part of activity, over last 7-day period, help of following type or types was provided 3 or more times: weight-bearing support or full staff performance during part (but not all) of last 7 days

e. (4) Total dependence Full staff performance of activity during entire 7 days

f. (8) Activity did not occur during the entire 7-day period. Use of this code is limited to situations where the ADL activity was not performed and is primarily applicable to fully bed-bound residents who neither transferred from bed nor moved between locations over the entire 7-day period.

3. Eating (§ E(1)(e)). In order to meet this ADL, the individual must score a 1, 2, 3, 4, or 8 as described below:

a. (0) Independent - No help or oversight - OR - help/oversight provided only 1 or 2 times during last 7 days

b. (1) Supervision - Oversight, encouragement or cueing provided 3+ times during last 7 days - OR -

supervision plus physical assistance provided on 1 or 2 times during last 7 days

c. (2) Limited assistance - Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3+ times - OR - more help provided only 1 or 2 times during last 7 days

d. (3) Extensive assistance - While resident performed part of activity, over last 7-day period, help of following type or types was provided 3 or more times: weight-bearing support or full staff performance during part (but not all) of last 7 days

e. (4) Total dependence - Full staff performance of activity during entire 7 days

f. (8) Activity did not occur during the entire 7-day period. Use of this code is limited to situations where the ADL activity was not performed and is primarily applicable to fully bed-bound residents who neither transferred from bed nor moved between locations over the entire 7 day period, or

g. To meet this ADL, one of the following is checked:

(1) § L(4)(a) Parenteral or intravenous

(2) § L(4)(b) Feeding tube

(3) § L(4)(d) Syringe (oral feeding)

4. Toilet Use (§ E(1)(f)). In order to meet this ADL, the individual must score a 1, 2, 3, 4, or 8 as described below:

a. (0) Independent - No help or oversight - OR - help/oversight provided only 1 or 2 times during last 7 days

b. (1) Supervision - Oversight, encouragement or cueing provided 3+ times during last 7 days - OR - supervision plus physical assistance provided on 1 or 2 times during last 7 days

c. (2) Limited assistance - Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3+ times - OR - more help provided only 1 or 2 times during last 7 days

d. (3) Extensive assistance - While resident performed part of activity, over last 7 day period, help of following type or types was provided 3 or more times: weight-bearing support or full staff performance during part (but not all) of last 7 days

e. (4) Total dependence - Full staff performance of activity during entire 7 days

f. (8) Activity did not occur during the entire 7-day period. Use of this code is limited to situations where the ADL activity was not performed and is primarily applicable to fully bed-bound residents who neither transferred from bed nor moved between locations over the entire 7-day period.

5. Bathing (§ E(3)(a)). To meet this ADL, the individual must score a 1, 2, 3, 4, or 8 as described below:

a. (0) Independent - no help provided.

b. (1) Supervision - oversight help only

c. (2) Physical help limited to transfer only

d. (3) Physical help in part of bathing activity

e. (4) Total dependence

f. (8) Activity did not occur during the entire 7-day period. Use of this code is limited to situations where the ADL activity was not performed and is primarily applicable to fully bed-bound residents who neither transferred from bed nor moved between locations over the entire 7-day period.

6. Bladder Continence (§ F(1)(b)). In order to meet this ADL, the individual must score a 2, 3, or 4 in this category:

a. (0) Continent - Complete control

b. (1) Usually continent - incontinent episodes once a week or less

c. (2) Occasionally incontinent - 2+ times a week but not daily

d. (3) Frequently incontinent - tended to be incontinent daily, but some control present (e.g., on day shift)

e. (4) Incontinent - Had inadequate control; multiple daily episodes or

f. To meet this ADL, one of the following is checked:

(1) § F(3)(b) external catheter

(2) § F(3)(c) indwelling catheter

7. Bowel Continence (§ F(1)(a)). In order to meet this ADL, the individual must score a 2, 3, or 4 in this category:

a. (0) Continent - Complete control

b. (1) Usually continent - control problems less than weekly

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- c. (2) Occasionally incontinent - once a week
- d. (3) Frequently incontinent - 2-3 times a week
- e. (4) Incontinent - Had inadequate control all (or almost all) of the time, or
- f. To meet this ADL, § F(3)(h) ostomy is checked.

B. Joint Motion (§ E(4)).

In order to meet this category, at least one of the following must be checked:

- 1. § E(4)(c) Contracture to arms, legs, shoulders, or hands
- 2. (d) Hemiplegia/hemiparesis
- 3. (e) Quadriplegia
- 4. (f) Arm - partial or total loss of voluntary movement
- 5. (g) Hand - lack of dexterity (e.g., problem using toothbrush or adjusting hearing aid)
- 6. (h) Leg - partial or total loss of voluntary movement
- 7. (i) Leg - unsteady gait
- 8. (j) Trunk - partial or total loss of ability to position, balance, or turn body

C. Locomotion (§ E(1)(c)).

In order to meet this ADL, the individual must score a 1, 2, 3, 4, or 8 in this category:

- 1. (0) Independent - No help or oversight - OR - help/oversight provided only 1 or 2 times during last 7 days
- 2. (1) Supervision - Oversight, encouragement or cueing provided 3+ times during last 7 days - OR - supervision plus physical assistance provided on 1 or 2 times during last 7 days
- 3. (2) Limited assistance - Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3+ times - OR - more help provided only 1 or 2 times during last 7 days
- 4. (3) Extensive assistance - While resident performed part of activity, over last 7 day period, help of following type or types was provided 3 or more times: weight-bearing support or full staff performance during part (but not all) of last 7 days

5. (4) Total dependence - Full staff performance of activity during entire 7 days

6. (8) Activity did not occur during the entire 7-day period. Use of this code is limited to situations where the ADL activity was not performed and is primarily applicable to fully bed-bound residents who neither transferred from bed nor moved between locations over the entire 7-day period.

D. Nursing Observation.

In order to meet this category, at least one of the following special treatments, procedures and skin conditions must be checked:

- 1. § N(4)(a) Open lesions other than stasis or pressure ulcers (e.g., cuts)
 - (f) Wound care or treatment (e.g., pressure ulcer care, surgical wound)
 - (g) Other skin care or treatment
- 2. § P(1)(a) Chemotherapy
 - (b) Radiation
 - (c) Dialysis
 - (d) Suctioning
 - (e) Tracheostomy care
 - (f) Intravenous medications
 - (g) Transfusions
 - (h) Oxygen
 - (i) Other special treatment or procedure

E. Behavior and Orientation.

In order to meet this category, the individual must meet at least one of the categories for both behavior and orientation.

1. Behavior. To meet the criteria for behavior, the individual must meet at least one of the following:

- a. § H(1)(d) Failure to eat or take medications, withdrawal from self care or leisure activities (must be checked), or
- b. One of the following is coded 1 (behavior of this type occurred less than daily) or 2 (behavior of this type occurred daily or more frequently):
 - (1) § H(3)(a) Wandering (moved with no rational purpose, seemingly oblivious to needs or safety)

(2) § H(3)(b) Verbally abusive (others were threatened, screamed at, cursed at)

(3) § H(3)(c) Physically abusive (others were hit, shoved, scratched, sexually abused)

(4) § H(3)(d) Socially inappropriate/disruptive behavior (made disrupting sounds, noisy, screams, self abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)

2. Orientation: To meet this category, the individual must meet at least one of the following:

a. § B(3)(d) Awareness that individual is in a nursing home - is not checked;

b. § B(3)(e) None of the memory/recall ability items are recalled - must be checked; or

c. § B(4) Cognitive skills for daily decision making - must be coded with a 2 (moderately impaired - decisions poor; cues/supervision required) or 3 (severely impaired never/rarely made decisions).

PART II. ADULT SPECIALIZED CARE CRITERIA.

§ 2.1. General description.

The resident must have long-term health conditions requiring close medical supervision, 24-hour licensed nursing care, and specialized services or equipment.

§ 2.2. Targeted population.

Targeted population includes:

1. Individuals requiring mechanical ventilation;
2. Individuals with communicable diseases requiring universal or respiratory precautions;
3. Individuals requiring ongoing intravenous medication or [intravenous] nutrition administration; and
4. Individuals requiring comprehensive rehabilitative therapy services.

§ 2.3. Criteria.

A. The individual must require at a minimum:

1. Physician visits at least once weekly;
2. Skilled nursing services 24 hours a day (a registered nurse must be on the nursing unit on which the resident resides, 24 hours a day, whose sole responsibility is the designated unit); and

3. Coordinated multidisciplinary team approach to meet needs.

B. In addition, the individual must meet one of the following requirements:

1. Must require two out of three of the following rehabilitative services: physical therapy, occupational therapy, speech-pathology services; therapy must be provided at a minimum of [four therapy sessions (minimum of 30 minutes per session) two hours of therapy] per day, five days per week; individual must demonstrate progress in overall rehabilitative plan of care on a monthly basis;

2. Must require special equipment such as mechanical ventilators, respiratory therapy equipment (that has to be supervised by licensed nurse or respiratory therapist), monitoring device (respiratory or cardiac) kinetic therapy; or

3. Individuals that require at least one of the following special services:

a. Ongoing administration of intravenous medications [~~of~~ or intravenous] nutrition (i.e., TPN, antibiotic therapy, narcotic administration, etc.);

b. Special infection control precautions (universal or respiratory precaution; this does not include handwashing precautions only);

c. Dialysis treatment that is provided on unit (i.e., peritoneal dialysis);

d. Daily respiratory therapy treatments that must be provided by a skilled nurse or respiratory therapist;

e. Extensive wound care requiring debridement, irrigation, packing, etc., more than two times a day (i.e., grade IV decubiti; large surgical wounds that cannot be closed, second or third-degree burns covering more than 10% of the body); or

f. Multiple unstable ostomies (a single ostomy does not constitute a requirement for special care) requiring frequent care (i.e., suctioning every hour stabilization of feeding; stabilization of elimination).

PART III. PEDIATRIC AND ADOLESCENT SPECIALIZED CARE CRITERIA.

§ 3.1. General description.

The child must have ongoing health conditions requiring close medical supervision, 24-hour licensed nursing supervision, and specialized services or equipment. The recipient must be age 21 or under.

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§ 3.2. Targeted population.

Targeted population includes:

1. Children requiring mechanical ventilation;
2. Children with communicable diseases requiring universal or respiratory precautions (excluding normal childhood diseases such as chicken pox, measles, strep throat, etc.);
3. Children requiring ongoing intravenous medication or [intravenous] nutrition administration;
4. Children requiring daily dependence on device based respiratory or nutritional support (tracheostomy, gastrostomy, etc.);
5. Children requiring comprehensive rehabilitative therapy service; and
6. Children with terminal illness.

§ 3.3. Criteria.

A. The child must require at a minimum:

1. Physician visits at least once weekly [~~;~~ . The initial physician visit must be made by the physician personally. Subsequent required physician visits after the initial visit may alternate between personal visits by the physician and visits by a physician assistant or nurse practitioner.]
2. Skilled nursing services 24 hours a day (a registered nurse must be on the nursing unit on which the child is residing, 24 hours a day, whose sole responsibility is that nursing unit);
3. Coordinated multidisciplinary team approach to meet needs; and
4. The nursing facility must [~~provided~~ coordinate with appropriate state and local agencies] for the educational and habilitative needs of the child. These services must be age appropriate and appropriate to the cognitive level of the child. Services must also be individualized to meet the specific needs of the child and must be provided in an organized and proactive manner. Services may include but are not limited to school, active treatment for mental retardation, habilitative therapies, social skills and leisure activities. The services must be provided for a total of two hours per day, minimum.

B. In addition, the child must meet one of the following requirements:

1. Must require two out of three of the following rehabilitative services: Physical Therapy, Occupational Therapy, Speech-pathology services; therapy must be

provided at a minimum of six therapy sessions (minimum of 15 minutes per session) per day, five days per week; child must demonstrate progress in overall rehabilitative plan of care on a monthly basis;

2. Must require special equipment such as mechanical ventilators, respiratory therapy equipment (that has to be supervised by licensed nurse or respiratory therapist), monitoring device (respiratory or cardiac) kinetic therapy, etc.; or

3. Children that require at least one of the following special services:

a. Ongoing administration of intravenous medications of nutrition (i.e., TPN, antibiotic therapy, narcotic administration, etc.);

b. Special infection control precautions (universal or respiratory precaution; this does not include handwashing precautions only or isolation for normal childhood diseases such as measles, chicken pox, strep throat, etc.);

c. Dialysis treatment that is provided within the facility (i.e., peritoneal dialysis);

d. Daily respiratory therapy treatments that must be provided by a skilled nurse or respiratory therapist;

e. Extensive wound care requiring debridement, irrigation, packing, etc., more than two times a day (i.e., grade IV decubiti; large surgical wounds that cannot be closed, second or third-degree burns covering more than 10% of the body);

f. Ostomy care requiring services by a licensed nurse; or

g. Care for terminal illness.

PART IV. CRITERIA FOR CARE IN FACILITIES FOR MENTALLY RETARDED PERSONS.

§ 4.1. Definitions.

The following words and terms, when used in these criteria, shall have the following meaning, unless the context clearly indicates otherwise:

"No assistance" means no help is needed.

"Prompting/structuring" means prior to the functioning, some verbal direction or some rearrangement of the environment is needed.

"Supervision" means that a helper must be present during the function and provide only verbal direction, general prompts, and/or guidance.

"Some direct assistance" means that helper must be present and provide some physical guidance/support (with or without verbal direction).

"Total care" means that a helper must perform all or nearly all of the functions.

"Rarely" means that a behavior occurs quarterly or less.

"Sometimes" means that a behavior occurs once a month or less.

"Often" means that a behavior occurs two or three times a month.

"Regularly" means that a behavior occurs weekly or more.

§ 4.2. Utilization control.

Utilization control regulations require that criteria be formulated for guidance for appropriate levels of services. Traditionally, care for the mentally retarded has been institutionally based; however, this level of care need not be confined to a specific setting. The habilitative and health needs of the client are the determining issues.

§ 4.3. Purpose.

The purpose of these regulations is to establish standard criteria to measure eligibility for Medicaid payment. Medicaid can pay for care only when the client is receiving appropriate services and when "active treatment" is being provided. An individual's need for care must meet these criteria before any authorization for payment by Medicaid will be made for either institutional or waived rehabilitative services for the mentally retarded.

§ 4.4. Care in facilities for the mentally retarded.

A. Care in facilities for mentally retarded requires planned programs for habilitative needs or health related services which exceed the level of room, board, and supervision of daily activities. Such cases shall be combination of habilitative, rehabilitative, and health services directed toward increasing the functional capacity of the retarded person. Examples of services shall include training in the activities of daily living, task-learning skills, socially acceptable behaviors, basic community living programming, or health care and health maintenance. The overall objective of programming shall be the attainment of the optimal physical, intellectual, social, or task learning level which the person can presently or potentially achieve.

B. The evaluation and reevaluation for care in a facility for the mentally retarded shall be based on the needs of the person, the reasonable expectations of the resident's capabilities, the appropriateness of programming, whether

progress is demonstrated from the training and, in an institution, whether the services could reasonably be provided in a less restrictive environment.

§ 4.5. Patient assessment criteria.

The patient assessment criteria are divided into broad categories of needs, or services provided. These must be evaluated in detail to determine the abilities/skills which will be the basis for the development of a plan for care. The evaluation process will demonstrate a need for programming an array of skills and abilities or health care services. These have been organized in seven major categories. Level of functioning in each category is graded from the most dependent to the least dependent. In some categories, the dependency status is rated by the degree of assistance required. In other categories, the dependency is established by the frequency of a behavior or ability to perform a given task.

§ 4.6. Categories.

The resident must meet the indicated dependency level in two or more of categories 1 through 7.

1. Health status. To meet this category:

a. Two or more questions must be answered with a 4, or

b. Question "j" must be answered "yes."

2. Communication skills. To meet this category three or more questions must be answered with a 3 or a 4.

3. Task learning skills. To meet this category three or more questions must be answered with a 3 or a 4.

4. Personal care. To meet this category:

a. Question "a" must be answered with a 4 or a 5, or

b. Question "b" must be answered with a 4 or a 5, or

c. Questions "c" and "d" must be answered with a 4 or a 5.

5. Mobility. To meet this category:

Any one question must be answered with a 4 or a 5.

6. Behavior. To meet this category:

Any one question must be answered with a 3 or a 4.

7. Community living. To meet this category:

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a. Any two of the questions "b," "e," or "g" must be answered with a 4 or a 5, or

b. Three or more questions must be answered with a 4 or a 5.

§ 4.7. Level of functioning survey.

A. HEALTH STATUS.

How often is nursing care or nursing supervision by a licensed nurse required for the following? (Key: 1=Rarely, 2=Sometimes, 3=Often, and 4=Regularly)

1. Medication administration and/or evaluation for effectiveness of a medication regimen? ..1.....2.....3.....4
2. Direct services: i.e., care for lesions, dressings, treatments, (other than shampoos, foot powder, etc.)1.....2.....3.....4
3. Seizures control1.....2.....3.....4
4. Teaching diagnosed disease control and care, including diabetes1.....2.....3.....4
5. Management of care of diagnosed circulatory or respiratory problems1.....2.....3.....4
6. Motor disabilities which interfere with all activities of Daily Living Bathing, Dressing, Mobility, Toileting, etc.1.....2.....3.....4
7. Observation for choking/aspiration while eating, drinking?1.....2.....3.....4
8. Supervision of use of adaptive equipment, i.e., special spoon, braces, etc.1.....2.....3.....4
9. Observation for nutritional problems (i.e., undernourishment, swallowing difficulties, obesity)1.....2.....3.....4
10. Is age 55 or older, has a diagnosis of a chronic disease and has been in an institution 20 years or more1.....2.....3.....4

B. COMMUNICATION.

Using the Key 1=regularly, 2=often, 3=sometimes, 4=rarely, how often does this person

1. Indicate wants by pointing, vocal noises, or signs?1.....2.....3.....4
2. Use simple words, phrases, short sentences?1.....2.....3.....4
3. Ask for at least ten things using appropriate names?1.....2.....3.....4

4. Understand simple words, phrases or instructions containing prepositions: i.e., "on" "in" "behind"? ..1.....2.....3.....4

5. Speak in an easily understood manner? ..1.....2.....3.....4

6. Identify self, place of residence, and significant others?1.....2.....3.....4

C. TASK LEARNING SKILLS.

How often does this person perform the following activities (Key: 1=regularly, 2=often, 3=sometimes, 4=rarely)

1. Pay attention to purposeful activities for 5 minutes?1.....2.....3.....4
2. Stay with a 3-step task for more than 15 minutes?1.....2.....3.....4
3. Tell time to the hour and understand time intervals?1.....2.....3.....4
4. Count more than 10 objects?1.....2.....3.....4
5. Do simple addition, subtraction?1.....2.....3.....4
6. Write or print ten words?1.....2.....3.....4
7. Discriminate shapes, sizes, or colors? ..1.....2.....3.....4
8. Name people or objects when describing pictures?1.....2.....3.....4
9. Discriminate between "one," "many," "lot"?1.....2.....3.....4

D. PERSONAL and SELF CARE.

With what type of assistance can this person currently (Key: 1=No Assistance, 2=Prompting/Structures, 3=Supervision, 4=Some Direct Assistance, 5=Total Care)

1. Perform toileting functions: i.e., maintain bladder and bowel continence, clean self, etc.?1.....2.....3.....4.....5
2. Perform eating/feeding functions: i.e., drinks liquids and eats with spoon or fork, etc.? ..1.....2.....3.....4.....5
3. Perform bathing function: i.e., bathe, runs bath, dry self, etc.?1.....2.....3.....4.....5
4. Dress self completely, i.e., including fastening, putting on clothes, etc.?1.....2.....3.....4.....5

E. MOBILITY.

With what type of assistance can this person currently

(Key: 1=No Assistance, 2=Prompting/Structures, 3=Supervision, 4=Some Direct Assistance, 5=Total Care)

1. Move, (walking, wheeling) around environment?
.....1.....2.....3.....4.....5

2. Rise from lying down to sitting positions, sits without support?1.....2.....3.....4.....5

3. Turn and position in bed, roll over?
.....1.....2.....3.....4.....5

F. BEHAVIOR.

How often does this person (Key: 1=Rarely, 2=Sometimes, 3=Often, and 4=Regularly)

1. Engage in self destructive behavior? ..1.....2.....3.....4

2. Threaten or do physical violence to others?
.....1.....2.....3.....4

3. Throw things, damage property, have temper outbursts?1.....2.....3.....4

4. Respond to others in a socially unacceptable manner (without undue anger, frustration, or hostility)
.....1.....2.....3.....4

G. COMMUNITY LIVING SKILLS.

With what type of assistance can this person currently (Key: 1=No Assistance, 2=Prompting/Structures, 3=Supervision, 4=Some Direct Assistance, 5=Total Care)

1. Prepare simple foods requiring no mixing or cooking?1.....2.....3.....4.....5

2. Take care of personal belongings, room (excluding vacuuming, ironing, clothes washing/drying, wet mopping)?1.....2.....3.....4.....5

3. Add coins of various denominations up to one dollar?1.....2.....3.....4.....5

4. Use the telephone to call home, doctor, fire, police?
.....1.....2.....3.....4.....5

5. Recognize survival signs/words: i.e., stop, go, traffic lights, police, men, women, restrooms, danger, etc.?1.....2.....3.....4.....5

6. Refrain from exhibiting unacceptable sexual behavior in public?1.....2.....3.....4.....5

7. Go around cottage, ward, building, without running away, wandering off, or becoming lost?
.....1.....2.....3.....4.....5

8. Make minor purchases, i.e., candy, soft drink, etc?
.....1.....2.....3.....4.....5

VR 460-04-3.1300. Regulations for Outpatient Physical Rehabilitative Services.

§ 1. Scope

A. Physical therapy and related services shall be defined as physical therapy, occupational therapy, and speech-language pathology services.

B. Physical therapy and related services shall be prescribed by a physician and be part of a written plan of care.

C. Any one of these services may be offered as the sole rehabilitative service and is not contingent upon the provision of another service.

D. All practitioners and providers of services shall be required to meet State and Federal licensing or certification requirements.

§ 2. Physical therapy.

A. Services for individuals requiring physical therapy are provided only as an element of hospital inpatient or outpatient service, nursing facility service, home health service, or when otherwise included as an authorized service by a cost provider who provides rehabilitation services, or by a school district employing qualified physical therapists.

B. Effective July 1, 1988, the Program will not provide direct reimbursement to enrolled providers for physical therapy service rendered to patients residing in long-term care facilities. Reimbursement for these services is and continues to be included as a component of the nursing facilities' operating cost.

C. Physical therapy services meeting all of the following conditions shall be furnished to patients:

1. The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a physical therapist licensed by the Board of Medicine.

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a physical therapist licensed by the Board of Medicine, or a physical therapy assistant who is licensed by the Board of Medicine and is under the direct supervision of a physical therapist licensed by the Board of Medicine. When physical therapy services are provided by a qualified physical therapy assistant, such services shall be provided under the supervision of a qualified physical therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.

3. The services shall be specific and provide effective

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treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

§ 3. Occupational therapy.

A. Services for individuals requiring occupational therapy are provided only as an element of hospital inpatient or outpatient service, nursing facility service, home health service, or when otherwise included as an authorized service by a cost provider who provides rehabilitation services, or a school district employing qualified therapists.

B. Effective September 1, 1990, Virginia Medicaid will not make direct reimbursement to providers for occupational therapy services for Medicaid recipients residing in long-term care facilities. Reimbursement for these services is and continues to be included as a component of the nursing facilities' operating cost.

C. Occupational therapy services shall be those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by the physician after any needed consultation with an occupational therapist registered and certified by the American Occupational Therapy Certification Board;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by an occupational therapist registered and certified by the American Occupational Therapy Certification Board, a graduate of a program approved by the Council on Medical Education of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association under the supervision of an occupational therapist as defined above, or an occupational therapy assistant who is certified by the American Occupational Therapy Certification Board under the direct supervision of an occupational therapist as defined above. When occupational therapy services are provided by a qualified occupational therapy assistant or a graduate engaged in supplemental clinical experience required before registration, such services shall be provided under the supervision of a qualified occupational therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

§ 4. Services for individuals with speech, hearing, and language disorders.

A. These services are provided by or under the supervision of a speech pathologist or an audiologist only as an element of hospital inpatient or outpatient service, nursing facility service, home health service, or when otherwise included as an authorized service by a cost provider who provides rehabilitation services.

B. Effective September 1, 1990, Virginia Medicaid will not make direct reimbursement to providers for speech-language pathology services for Medicaid recipients residing in long-term care facilities. Reimbursement for these services is and continues to be included as a component of the nursing facilities' operating cost.

C. Speech-language therapy services shall be those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a speech-language pathologist licensed by the Board of Audiology and ~~Speech~~ *Speech-Language* Pathology, or, if exempted from licensure by statute, meeting the requirements in 42 CFR 440.110(c);

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a speech-language pathologist licensed by the Board of Audiology and ~~Speech~~ *Speech-Language* Pathology; and

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

§ 5. Authorization for services.

A. Physical therapy, occupational therapy, and speech-language pathology services provided in outpatient settings of acute and rehabilitation hospitals, rehabilitation agencies, *school divisions*, or home health agencies shall include authorization for up to 24 visits by each ordered rehabilitative service ~~within a 60-day period. A recipient may receive a maximum of 48 visits annually without authorization.~~ *annually*. The provider shall maintain documentation to justify the need for services. A visit shall be defined as the duration of time that a rehabilitative therapist is with a client to provide services prescribed by the physician. Visits shall not be defined in measurements or increments of time.

B. The provider shall request from DMAS authorization for treatments deemed necessary by a physician beyond the number authorized by using the ~~Rehabilitation~~

Treatment Authorization form (DMAS-125). This request must be signed and dated by a physician. Documentation for medical justification must include physician orders or a plan of care signed and dated by the physician. Authorization for extended services shall be based on individual need. Payment shall not be made for additional service unless the extended provision of services has been authorized by DMAS. Periods of care beyond those allowed which have not been authorized by DMAS shall not be approved for payment.

§ 6. Documentation requirements.

A. Documentation of physical therapy, occupational therapy, and speech-language pathology services provided by a hospital-based outpatient setting, home health agency, a rehabilitation agency, or a school district shall, at a minimum:

1. Describe the clinical signs and symptoms of the patient's condition;
2. Include an accurate and complete chronological picture of the patient's clinical course and treatments;
3. Document that a plan of care specifically designed for the patient has been developed based upon a comprehensive assessment of the patient's needs;
4. Include all treatment rendered to the patient in accordance with the plan with specific attention to frequency, duration, modality, response, and identify who provided care (include full name and title);
5. Include a copy of the physician's orders and plan of care;
6. Describe changes in each patient's condition and response to the rehabilitative treatment plan;
7. (Except for school districts) describe a discharge plan which includes the anticipated improvements in functional levels, the time frames necessary to meet these goals, and the patient's discharge destination; and
8. I school districts, include an individualized education program (IEP) which describes the anticipated improvements in functional level in each school year and the time frames necessary to meet these goals.

B. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

§ 7. Service limitations.

The following general conditions shall apply to reimbursable physical therapy, occupational therapy, and

speech-language pathology services:

1. Patient must be under the care of a physician who is legally authorized to practice and who is acting within the scope of his license.
2. Services shall be furnished under a written plan of treatment and must be established and periodically reviewed by a physician. The requested services or items must be necessary to carry out the plan of treatment and must be related to the patient's condition.
3. A physician recertification shall be required periodically, must be signed and dated by the physician who reviews the plan of treatment, and may be obtained when the plan of treatment is reviewed. The physician recertification statement must indicate the continuing need for services and should estimate how long rehabilitative services will be needed.
4. The physician orders for therapy services shall include the specific procedures and modalities to be used, identify the specific discipline to carry out the plan of care, and indicate the frequency and duration for services.
5. Utilization review shall be performed to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.
6. Rehabilitation care is to be terminated regardless of the approved length of stay when further progress toward the established rehabilitation goal is unlikely or when the services can be provided by someone other than the skilled rehabilitation professional.

VR 460-04-8.10. Regulation for Long-Stay Acute Care Hospitals.

§ 1. Scope.

Medicaid shall cover long-stay acute care hospital services as defined in § 2 provided by hospitals certified as long-stay acute care hospitals and which have provider agreements with the Department of Medical Assistance Services.

§ 2. Authorization for services.

Long-stay acute care hospital stays shall be preauthorized by the submission of a completed comprehensive assessment instrument, a physician certification of the need for long-stay acute care hospital placement, and any additional information that justifies the need for intensive services. Prior authorization shall be

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required by submission of the information described above. Physician certification must accompany the request. Periods of care not authorized by the Department of Medical Assistance Services shall not be approved for payment.

§ 3. Criteria for long-stay acute care hospital stays.

A. Adult long-stay acute care hospital criteria.

1. The resident must have long-term health conditions requiring close medical supervision, 24-hour licensed nursing care, and specialized services or equipment needs. The population to be served includes individuals requiring mechanical ventilation, individuals with communicable diseases requiring universal or respiratory precautions, individuals requiring ongoing intravenous medication or nutrition administration, and individuals requiring comprehensive rehabilitative therapy services.

2. At a minimum, the individual must require physician visits at least once weekly, licensed nursing services 24 hours a day (a registered nurse whose sole responsibility is the designated unit must be on the nursing unit on which the resident resides, 24 hours a day), and coordinated multidisciplinary team approach to meet needs.

3. In addition, the individual must meet at least one of the following requirements:

a. Must require two out of three of the following rehabilitative services: physical therapy, occupational therapy, speech-pathology services; each required therapy must be provided daily, five days per week, for a minimum of one hour each day; individual must demonstrate progress in overall rehabilitative plan of care on a monthly basis; or

b. Must require special equipment such as mechanical ventilators, respiratory therapy equipment (that has to be supervised by a licensed nurse or respiratory therapist), monitoring device (respiratory or cardiac), kinetic therapy; or

c. The individual must require at least one of the following special services:

(1) Ongoing administration of intravenous medications or nutrition (i.e. total parenteral nutrition (TPN), antibiotic therapy, narcotic administration, etc.);

(2) Special infection control precautions such as universal or respiratory precaution (this does not include handwashing precautions only);

(3) Dialysis treatment that is provided on-unit (i.e. peritoneal dialysis);

(4) Daily respiratory therapy treatments that must be provided by a licensed nurse or a respiratory therapist;

(5) Extensive wound care requiring debridement, irrigation, packing, etc., more than two times a day (i.e. grade IV decubiti; large surgical wounds that cannot be closed; second- or third-degree burns covering more than 10% of the body); or

(6) Multiple unstable ostomies (a single ostomy does not constitute a requirement for special care) requiring frequent care (i.e. suctioning every hour, stabilization of feeding, stabilization of elimination, etc.)

B. Pediatric/adolescent patients in long-stay acute care hospitals criteria.

1. To be eligible for long-stay acute care hospital services, the child must have ongoing health conditions requiring close medical supervision, 24-hour licensed nursing supervision, and specialized services or equipment needs. The recipient must be age 21 or under. The population to be served includes children requiring mechanical ventilation, those with communicable diseases requiring universal or respiratory precautions (excluding normal childhood diseases such as chicken pox, measles, strep throat, etc.), those requiring ongoing intravenous medication or nutrition administration, those requiring daily dependence on device-based respiratory or nutritional support (tracheostomy, gastrostomy, etc.), those requiring comprehensive rehabilitative therapy services, and those with a terminal illness.

2. The child must minimally require physician visits at least once weekly, licensed nursing services 24 hours a day (a registered nurse whose sole responsibility is that nursing unit must be on the unit on which the child is residing 24 hours a day), and a coordinated multidisciplinary team approach to meet needs.

3. In addition, the child must meet one of the following requirements:

a. Must require two out of three of the following physical rehabilitative services: physical therapy, occupational therapy, speech-pathology services; each required therapy must be provided daily, five days per week, for a minimum of 45 minutes per day; child must demonstrate progress in overall rehabilitative plan of care on a monthly basis; or

b. Must require special equipment such as mechanical ventilators, respiratory therapy equipment (that has to be supervised by licensed nurse or respiratory therapist), monitoring device (respiratory or cardiac), kinetic therapy, etc; or

c. Must require at least one of the following special

services:

(1) Ongoing administration of intravenous medications or nutrition (i.e. total parenteral nutrition (TPN), antibiotic therapy, narcotic administration, etc.);

(2) Special infection control precautions such as universal or respiratory precaution (this does not include handwashing precautions only or isolation for normal childhood diseases such as measles, chicken pox, strep throat, etc.);

(3) Dialysis treatment that is provided within the facility (i.e. peritoneal dialysis);

(4) Daily respiratory therapy treatments that must be provided by a licensed nurse or a respiratory therapist;

(5) Extensive wound care requiring debridement, irrigation, packing, etc., more than two times a day (i.e., grade IV decubiti; large surgical wounds that cannot be closed; second- or third-degree burns covering more than 10% of the body);

(6) Ostomy care requiring services by a licensed nurse;

(7) Services required for terminal care.

4. In addition, the long-stay acute care hospital must provide for the educational and habilitative needs of the child. These services must be age appropriate, must meet state educational requirements, and must be appropriate to the child's cognitive level. Services must also be individualized to meet the specific needs of the child and must be provided in an organized manner that encourages the child to participate. Services may include, but are not limited to, school, active treatment for mental retardation, habilitative therapies, social skills, and leisure activities. Therapeutic leisure activities must be provided daily. The services must be provided for a minimum of two hours per day.

§ 4. Documentation requirements.

A. Services not specifically documented in the resident's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

B. The long-stay acute care hospital shall maintain and retain the business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. Such records shall be retained for a period of not less than five years from the date of service or as provided by applicable state laws, whichever period is longer, except that, if an audit is initiated within the required retention period, the records

must be retained until the audit is completed and every exception resolved.

C. The following documentation must be maintained in the resident's medical record:

1. Each record must identify the resident on each page.

2. Entries must be signed and dated (month, day, and year) by the author, followed by professional title. Care rendered by personnel under the supervision of the provider, which is in accordance with Medicaid policy, must be countersigned by the responsible licensed participating provider.

3. The attending physician must certify at the time of admission that the resident requires long-stay acute hospital care and meets the criteria as defined by DMAS.

4. The record must contain a preliminary working diagnosis and the elements of a history and physical examination upon which the diagnosis is based.

5. All services provided, as well as any treatment plan, must be entered in the record. Any drugs prescribed and administered as part of a physician's treatment plan, including the quantities, route of administration, and the dosage must be recorded.

6. The record must indicate the resident's progress, any change in diagnosis or treatment, and the response to the treatment. The documentation must include in detail all treatment rendered to the resident in accordance with the plan with specific attention to frequency, duration, modality, response to treatment, and identify who provided such treatment.

7. Physician progress notes must be written at least weekly and must reflect that the resident has been examined by the physician.

8. A comprehensive nursing assessment must be made by a registered nurse at the time of admission to the facility. Nursing care plans based on an admission assessment must be resident-specific and must indicate realistic nursing needs, measurable goals, and specifically state the method by which the goals are to be accomplished. They must be updated as needed, but at least monthly. Nursing summaries, in addition to the p.r.n. (as needed) notes, are required weekly. Nursing summaries must give a current, written picture of the resident, the resident's nursing needs, the care being provided, and the resident's response to treatment. The nursing summary at a minimum must address the following: medical status; functional status in activities of daily living, elimination, mobility, and emotional/mental status; special nursing procedures; and identification and resolution of acute illnesses or episodes.

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9. Social services documentation must include a social evaluation and history and a social services plan of care including a discharge plan. The social work plans of care must be resident-specific and include measurable goals with realistic time frames. Social work plans of care must be updated as needed and at least monthly every 30 days. Social services progress notes must be written at least every 30 days.

10. Activities documentation must be based on a comprehensive assessment completed by the designated activity coordinator. An activity plan of care must be developed for each resident and must include consideration of the individual's interests and skills, the physician's recommendations, social and rehabilitation goals, and personal care requirements. Individual and group activities must be included in the plan. The activity plan of care must be updated as needed but at least every 30 days. Activity progress notes must be written at least every 30 days. Therapeutic leisure activities must be provided daily.

11. Rehabilitative therapy (physical and occupational therapy or speech-language services) or other health care professional (psychologist, respiratory therapist, etc.) documentation must include an assessment completed by the qualified rehabilitation professional. A plan of care developed specific to the resident must be developed and must include measurable goals with realistic time frames. The plan of care must be updated as needed but at least every 30 days. Rehabilitative therapy or other health care professional progress notes must be written at least every 30 days.

12. Each resident's record must contain a dietary evaluation and plan of care completed by a registered dietician. The plan of care must be resident-specific and must have measurable goals within realistic time frames. The plan of care must be updated as needed, but at least every 30 days. The dietary assessment and monthly plans of care must be completed by a registered dietician. Dietary progress notes must be written at least every 30 days.

13. A coordinated interdisciplinary plan of care must be developed for each resident. The plan of care must be resident-specific and must contain measurable goals within realistic time frames. Based on the physician's plan of care, the interdisciplinary team should include, but is not necessarily limited to, nurses, social workers, activities coordinators, dietitians, rehabilitative therapists, direct care staff, and the resident or responsible party. At a minimum, the interdisciplinary team must review and update the interdisciplinary plan of care as needed but at least every 30 days. The interdisciplinary plan of care review must identify those attending the meeting, changes in goals and approaches, and progress made toward meeting established goals and discharge.

14. For residents age 21 and younger, the record must contain documentation that educational or habilitative services are provided as required. The documentation shall include an evaluation of the resident's educational or habilitative needs, a description of the educational or habilitative services provided, a schedule of planned programs, and records of resident attendance. Educational or habilitative progress notes shall be written at least every 30 days.

§ 5. Long-stay acute care hospital services.

All services must be provided by appropriately qualified personnel. The following services are covered long-stay acute care hospital services:

A. Physician services.

1. Physician services shall be performed by a professional who is licensed to practice in the Commonwealth, who is acting within the scope of his license, and who is a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor.

2. An attending physician means a physician who is a doctor of medicine or osteopathy and is identified by the individual as having the most significant role in the determination and delivery of the individual's medical care.

B. Licensed nursing services.

1. Must be provided 24 hours a day (a registered nurse, whose sole responsibility is the designated unit on which the resident resides, must be on the unit 24 hours a day).

2. Nursing services shall be of a level of complexity and sophistication, or the condition of the resident shall be of a nature, that the services can only be performed by a registered nurse or licensed professional nurse, or nursing assistant under the direct supervision of a registered nurse who is experienced in providing the specialized care required by the resident.

C. Rehabilitative services.

1. Rehabilitative services shall be directly and specifically related to written plan of care designed by a physician after any needed consultation with the rehabilitation professional.

2. Physical therapy services shall be of a level of complexity and sophistication, or the condition of the resident shall be of a nature, that the services can only be performed by a physical therapist licensed by the Board of Medicine, or a physical therapy assistant who is licensed by the Board of Medicine and under

the direct supervision of a physical therapist licensed by the Board of Medicine.

3. Occupational therapy services shall be of a level of complexity and sophistication, or the condition of the resident shall be of a nature, that the services can only be performed by an occupational therapist registered and certified by the American Occupational Therapy Certification Board or an occupational therapy assistant certified by the American Occupational Therapy Certification Board under the direct supervision of an occupational therapist as defined.

4. Speech-language services shall be of a level of complexity and sophistication, or the condition of the resident shall be of a nature that the services can only be performed by a speech-language pathologist licensed by the Board of Audiology and ~~Speech~~ *Speech-Language Pathology*.

D. Ancillary services shall be provided directly and specifically related to a plan of care designed by the physician. The ancillary services may include but are not limited to dietary, respiratory therapy services, and psychological services.

1. Dietary services must be of a level of complexity or sophistication, or the nature of the resident shall be of a nature that the services can only be performed or supervised by a dietician, registered with the American Dietetic Association.

2. Respiratory therapy services must be of a level of complexity and sophistication, or the nature of the resident shall be of a nature that the services can only be performed by a respiratory therapist. Respiratory therapy services must be provided by a respiratory therapist certified by the Board of Medicine or registered with the National Board for Respiratory Care. If the facility agrees to provide care to a resident who is dependent on mechanical assistance for respiration (positive or negative pressure mechanical ventilators), respiratory therapy services must be available 24 hours daily. If the facility contracts for respiratory therapy services, a respiratory therapist must be on call 24 hours daily and available to the facility in a timely manner.

3. Psychology services shall be of a level of complexity or sophistication, or the condition shall be of a nature that the services can only be performed by a psychologist licensed by the Board of Medicine *or by a licensed clinical social worker under the direct supervision of a licensed clinical psychologist or a licensed psychologist clinical*.

4. Activity programs under the supervision of designated activities coordinators. The program of activities must include both individual and group activities which are based on consideration of interest,

skills, physical and mental status, and personal care requirements.

5. Provide social services to each resident in an effort to assist the resident, his family and the facility staff in understanding the significant social and emotional factors related to the health problems, to assist with appropriate utilization of community resources and to coordinate discharge plans. Social services must be provided by a social worker with at least a bachelor's degree in social work or similar qualifications.

§ 6. Long-stay acute care hospital requirements.

A. A coordinated multidisciplinary team approach shall be implemented to meet the needs of the resident. Based on the physician's plan of care, the interdisciplinary team should include, but is not necessarily limited to, nurses, social workers, activity coordinators, dieticians, rehabilitative therapists, and any direct care staff.

B. The long-stay acute care hospital shall provide for the educational and habilitative needs of residents age 21 or younger. These services must be age appropriate, must meet state educational requirements, and must be appropriate to the child's cognitive level. Services must be individualized to meet the specific needs of the child and must be provided in an organized manner which encourages the child to participate. Services may include but are not limited to school, active treatment for mental retardation, habilitative therapies, social skills and leisure activities. Therapeutic leisure activities must be provided daily.

C. The long-stay acute care hospital shall provide an acceptable plan for assuring that residents requiring long-stay acute hospital care are afforded the same opportunity for participating in integrated facility activities as the other facility residents.

D. Nonemergency transportation shall be provided so that residents may participate in community activities sponsored by the facility or community activities in which the facility is providing transportation for other facility residents.

E. The long-stay acute care hospital shall coordinate discharge planning for the resident utilizing all available resources in an effort to assist the resident to maximize his potential for independence and self-sufficiency and to assure that services are being provided by the most effective level of care.

F. The long-stay acute care hospital shall provide family or caregiver training in the skills necessary for the care of the resident in the community, should the resident or the resident's caregiver so desire.

G. The long-stay acute care hospital shall provide all necessary durable medical equipment to sustain life or monitor vital signs and to carry out a plan of care

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designed by the physician. This equipment may include but is not limited to mechanical ventilator, apnea monitor, etc.

H. The long-stay acute care hospital shall provide utilization review activities as follows:

1. Purpose. The objective of the utilization review mechanism is the maintenance of high-quality patient care and the most efficient utilization of resources through an educational approach involving the study of patient care as well as to ensure that inpatient care is provided only when medically necessary and that the care meets quality standards.

a. In addition to the certification by the resident's physician, the hospital shall have a utilization review plan which provides for review of all Medicaid patient stays and medical care evaluation studies of admissions, durations of stay, and professional services rendered.

b. Effective utilization review shall be maintained on a continuing basis to ensure the medical necessity of the services for which the program pays and to promote the most efficient use of available health facilities and services.

2. The Department of Medical Assistance Services delegates to the local facilities' utilization review departments the utilization review of inpatient hospital services for all Medicaid admissions. The hospital must have a utilization review plan reflecting 100% review of Medicaid residents, approved by the Division of Licensure and Certification of the Department of Health, and DMAS or the appropriate licensing agency in the state in which the institution is licensed.

3. The hospital utilization review coordinator shall approve the medical necessity, based on admission criteria approved by the utilization review committee, within one working day of admission. In the event of an intervening Saturday, Sunday, or holiday, a review must be performed the next working day. This review shall be reflected in the hospital utilization review plan and the resident's record.

4. If the admission is determined medically necessary, an initial stay review date must be assigned and reflected on the utilization review sheets. Continued or extended stay review must be assigned prior to or on the date assigned for the initial stay. If the facility's utilization review committee has reason to believe that an inpatient admission was not medically necessary, it may review the admission at any time. However, the decision of a utilization review committee in one facility shall not be binding upon the utilization review committee in another facility.

5. If the admission or continued stay is found to be medically unnecessary, the attending physician shall

be notified and be allowed to present additional information. If the hospital physician advisor still finds the admission or continued stay unnecessary, a notice of adverse decision must be made within one working day after the admission or continued stay is denied. Copies of this decision must be sent by the utilization review committee's designated agent to the hospital administrator, attending physician, recipient or recipient's authorized representative, and Medicaid.

6. As part of the utilization review plan, long-stay acute care hospitals shall have one medical or patient care evaluation study in process and one completed each calendar year. Medical care evaluation studies must contain the elements mandated by 42 CFR 456.141 through 456.145. The elements are objectives of study, results of the study, evaluation of the results, and action plan or recommendations as indicated by study results.

7. The Department of Medical Assistance Services shall monitor the length of stay for inpatient hospital stays. The guidelines used shall be based on the criteria described in § 3 of these regulations. If the stay or any portion of the stay is found to be medically unnecessary, contrary to program requirements, or if the required documentation has not been received, reimbursement will not be made by Medicaid.

8. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

I. The long-stay acute care hospital shall provide all medical supplies necessary to provide care as directed by the physician's plan of care for the resident. These supplies may include but are not limited to suction catheters, tracheostomy care supplies, oxygen, etc.

J. The long-stay acute care hospital shall provide all nutritional elements including those that must be administered intravenously. This includes providing all necessary equipment or supplies necessary to administer the nutrients.

K. The long-stay acute care hospital shall submit all necessary health care and medical social service information on the resident to DMAS for preadmission authorization. The provider cannot bill DMAS for services that have not been preauthorized.

VA.R. Doc. No. R94-980; Filed May 11, 1994, 11:47 a.m.

VIRGINIA UNIFORM ASSESSMENT INSTRUMENT

Dates: Screen: ____/____/____
 Assessment: ____/____/____
 Reassessment: ____/____/____

1 IDENTIFICATION/BACKGROUND

Name & Vital Information

Client Name: _____ (Last) (First) (Middle Initial) Client SSN: _____
 Address: _____ (Street) (City) (State) (Zip Code)
 Phone: () _____ City/County Code: _____

Directions to House: _____ Pets? _____

Demographics

Birthdate: ____/____/____ (Month) (Day) (Year) Age: _____ Sex: ____ Male 0 ____ Female 1
 Marital Status: ____ Married 0 ____ Widowed 1 ____ Separated 2 ____ Divorced 3 ____ Single 4 ____ Unknown 9
 Race: _____ Education: _____ Communication of Needs: _____
 ____ White 0 ____ Less than High School 0 ____ Verbally, English 0
 ____ Black/African American 1 ____ Some High School 1 ____ Verbally, Other Language 1
 ____ American Indian 2 ____ High School Graduate 2 ____ Specify: _____
 ____ Oriental/Asian 3 ____ Some College 3 ____ Sign Language/Gestures/Device 2
 ____ Alaskan Native 4 ____ College Graduate 4 ____ Does Not Communicate 3
 ____ Unknown 9 ____ Unknown 9 ____ Hearing Impaired? _____
 Ethnic Origin: _____ Specify: _____

Primary Caregiver/Emergency Contact/Primary Physician

Name: _____ Relationship: _____
 Address: _____ Phone: (H) _____ (W) _____
 Name: _____ Relationship: _____
 Address: _____ Phone: (H) _____ (W) _____
 Name of Primary Physician: _____ Phone: _____
 Address: _____

Initial Contact

Who called: _____ (Name) (Relation to Client) (Phone)
 Presenting Problem/Diagnosis: _____

Client Name: _____ Client SSN: _____

Current Formal Services

Do you currently use any of the following types of services?

No	Yes	Check All Services That Apply	Provider/Frequency:
____	____	Adult Day Care	_____
____	____	Adult Protective	_____
____	____	Case Management	_____
____	____	Chore/Companion/Homemaker	_____
____	____	Congregate Meals/Senior Center	_____
____	____	Financial Management/Counseling	_____
____	____	Friendly Visitor/Telephone Reassurance	_____
____	____	Habilitation/Supported Employment	_____
____	____	Home Delivered Meals	_____
____	____	Home Health/Rehabilitation	_____
____	____	Home Repairs/Weatherization	_____
____	____	Housing	_____
____	____	Legal	_____
____	____	Mental Health (Inpatient/Outpatient)	_____
____	____	Mental Retardation	_____
____	____	Personal Care	_____
____	____	Respite	_____
____	____	Substance Abuse	_____
____	____	Transportation	_____
____	____	Vocational Rehab/Job Counseling	_____
____	____	Other:	_____

Financial Resources

Where are you on this scale for annual (monthly) family income before taxes?

____ \$20,000 or More (\$1,667 or More) 0
 ____ \$15,000 - \$19,999 (\$1,250 - \$1,666) 1
 ____ \$11,000 - \$14,999 (\$ 917 - \$1,249) 2
 ____ \$ 9,500 - \$10,999 (\$ 792 - \$ 916) 3
 ____ \$ 7,000 - \$ 9,499 (\$ 583 - \$ 791) 4
 ____ \$ 5,500 - \$ 6,999 (\$ 458 - \$ 582) 5
 ____ \$ 5,499 or Less (\$ 457 or Less) 6
 ____ Unknown 9

Number in Family unit: _____

Optional: Total monthly family income: _____

Do you currently receive income from ...?

No	Yes	Optional: Amount
____	____	Black Lung
____	____	Pension
____	____	Social Security
____	____	SSI/SSDI
____	____	VA Benefits
____	____	Wages/Salary
____	____	Other

Does anyone cash your check, pay your bills or manage your business?

No	Yes	Names
____	____	Legal Guardian
____	____	Power of Attorney
____	____	Representative Payee
____	____	Other

Do you receive any benefits or entitlements?

No	Yes	
____	____	Auxiliary Grant
____	____	Food Stamps
____	____	Fuel Assistance
____	____	General Relief
____	____	State and Local Hospitalization
____	____	Subsidized Housing
____	____	Tax Relief

What types of health insurance do you have?

No	Yes	
____	____	Medicare, # _____
____	____	Medicaid, # _____
____	____	Pending: <input type="checkbox"/> No <input type="checkbox"/> Yes
____	____	QMB/SLMB: <input type="checkbox"/> No <input type="checkbox"/> Yes

CLIENT NAME: _____ Client SSN: _____

Physical Environments

Where do you usually live? Does anyone live with you?

	Alone 1	Spouse 2	Other 3	Names of Persons in Household	
House: Own 0					
House: Rent 1					
House: Other 2					
Apartment 3					
Rented Room 4					
Name of Provider (Place)				Admission Date	Provider Number (If Applicable)
Adult Care Residence 50					
Adult Foster 60					
Nursing Facility 70					
Mental Health/Retardation Facility 80					
Other 90					

Where you usually live, are there any problems?

No 0	Yes 1	Check All Problems That Apply	Describe Problems:
		Barriers to Access	
		Electrical Hazards	
		Fire Hazards/No Smoke Alarm	
		Insufficient Heat/Air Conditioning	
		Insufficient Hot Water/Water	
		Lack of/Poor Toilet Facilities (Inside/Outside)	
		Lack of/Defective Stove, Refrigerator, Freezer	
		Lack of/Defective Washer/Dryer	
		Lack of/Poor Bathing Facilities	
		Structural Problems	
		Telephone Not Accessible	
		Unsafe Neighborhood	
		Unsafe/Poor Lighting	
		Unsanitary Conditions	
		Other: _____	

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CLIENT NAME: _____ Client SSN: _____

2 FUNCTIONAL STATUS (Check only one block for each level of functioning)

ADELS	Needs Help?	MH Only 10	HH Only 2	MH & HH 3	Performed by Others 40	Is Not Performed	
		Mechanical Help	Human Help	Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2
Bathing	No 00 Yes						
Dressing							
Toileting							
Transferring							
Eating/Feeding					Spoon Fed 1	Syringe/Tube Fed 2 IV 3	
Continence	Needs Help?	Incontinent	External Device/Indwelling/Ostomy	Incontinent	External Device	Indwelling Catheter	Ostomy
	No 00 Yes	Less than weekly 1	Self care 2	Weekly or more 3	Not self care 4	Not self care 5	Not self care
Bowel							
Bladder							

Comments:

Ambulations	Needs Help?	MH Only 10	HH Only 2	MH & HH 3	Performed by Others 40	Is Not Performed 50
		Mechanical Help	Human Help	Supervision 1	Physical Assistance 2	Supervision 1
Walking	No 00 Yes					
Wheeling						
Stairclimbing						
Mobility					Confined Moves About	Confined Does Not Move At

IADLS	Needs Help?
	No 0 Yes 1
Meal Preparation	
Housekeeping	
Laundry	
Money Management	
Transportation	
Shopping	
Using Phone	
Home Maintenance	

Comments:

Outcome: Is this a short assessment?

____ No, Continue with Section 60 ____ Yes, Service Referrals 1 ____ Yes, No Service Referrals

Screened: _____ Agency: _____

[illegible]

Client Name:		Client SSN:	
Sensory Functions			
How is your vision, hearing, and speech?			
No Impairment 0	Impairment	Complete Loss 3	Date of Last Exam
Record Date of Onset/Type of Impairment	Compensation 1	No Compensation 2	
Vision			
Hearing			
Speech			
Physical Status			
Joint Motion: How is your ability to move your arms, fingers and legs?			
<input type="checkbox"/> Within normal limits or instability corrected 0 <input type="checkbox"/> Limited motion 1 <input type="checkbox"/> Instability uncorrected or immobile 2 <input type="checkbox"/> Have you ever broken or dislocated any bones ... Ever had an amputation or lost any limbs ... Lost voluntary movement of any part of your body?			
Fractures/Dislocations	Missing Limbs	Paralysis/Paresis	
<input type="checkbox"/> None 000 <input type="checkbox"/> Hip Fracture 1 <input type="checkbox"/> Other Broken Bone(s) 2 <input type="checkbox"/> Dislocations(s) 3 <input type="checkbox"/> Combination 4 <input type="checkbox"/> Previous Rehab Program?	<input type="checkbox"/> None 000 <input type="checkbox"/> Finger(s)/Toe(s) 1 <input type="checkbox"/> Arm(s) 2 <input type="checkbox"/> Leg(s) 3 <input type="checkbox"/> Combination 4 <input type="checkbox"/> Previous Rehab Program?	<input type="checkbox"/> No/Not Completed 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> Date of Amputation?	
<input type="checkbox"/> No/Not Completed 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> Date of Fracture/Dislocation?	<input type="checkbox"/> No/Not Completed 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> Date of Amputation?	<input type="checkbox"/> No/Not Completed 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> Onset of Paralysis?	
<input type="checkbox"/> 1 Year or Less 1 <input type="checkbox"/> More than 1 Year 2	<input type="checkbox"/> 1 Year or Less 1 <input type="checkbox"/> More than 1 Year 2	<input type="checkbox"/> 1 Year or Less 1 <input type="checkbox"/> More than 1 Year 2	
Nutrition			
Weight: _____ (inches)	Weight: _____ (lbs.)	Recent Weight Gain/Loss: _____ No 0 _____ Yes 1	
Are you on any special diet(s) for medical reasons?		Do you have any problems that make it hard to eat?	
<input type="checkbox"/> None 0 <input type="checkbox"/> Low Fat/Cholesterol 1 <input type="checkbox"/> No/Low Salt 2 <input type="checkbox"/> No/Low Sugar 3 <input type="checkbox"/> Combination/Other 4	<input type="checkbox"/> None 0 <input type="checkbox"/> Occasional 1 <input type="checkbox"/> Daily Not Primary Source 2 <input type="checkbox"/> Daily Primary Source 3	<input type="checkbox"/> No 0 <input type="checkbox"/> Food Allergies <input type="checkbox"/> Inadequate Food/Fluid Intake <input type="checkbox"/> Nausea/Vomiting/Diarrhea <input type="checkbox"/> Problems Eating Certain Foods <input type="checkbox"/> Problems Following Special Diets <input type="checkbox"/> Problems Swallowing <input type="checkbox"/> Taste Problems <input type="checkbox"/> Tooth or Mouth Problems <input type="checkbox"/> Other:	
Do you take dietary supplements?			
<input type="checkbox"/> None 0 <input type="checkbox"/> Occasional 1 <input type="checkbox"/> Daily Not Primary Source 2 <input type="checkbox"/> Daily Primary Source 3			

Client Name: _____		Client SSN: _____	
Current Medical Services			
Rehabilitation Therapies: Do you get any therapy prescribed by a doctor, such as...?		Special Medical Procedures: Do you receive any special nursing care, such as...?	
No 0 Yes 1 Frequency	No 0 Yes 1 Site, Type, Frequency		
<input type="checkbox"/> Occupational <input type="checkbox"/> Physical <input type="checkbox"/> Reality/Remotivation <input type="checkbox"/> Respiratory <input type="checkbox"/> Speech <input type="checkbox"/> Other _____	<input type="checkbox"/> Bowel/Bladder Training <input type="checkbox"/> Dialysis <input type="checkbox"/> Dressing/Wound Care <input type="checkbox"/> Eyecare <input type="checkbox"/> Glucose/Blood Sugar <input type="checkbox"/> Injections/IV Therapy <input type="checkbox"/> Oxygen <input type="checkbox"/> Radiation/Chemotherapy <input type="checkbox"/> Restraints (Physical/Chemical) <input type="checkbox"/> ROM Exercise <input type="checkbox"/> Trach Care/Suctioning <input type="checkbox"/> Ventilator <input type="checkbox"/> Other: _____		
Do you have any pressure ulcers?			
None 0 Location/Size <input type="checkbox"/> Stage I 1 <input type="checkbox"/> Stage II 2 <input type="checkbox"/> Stage III 3 <input type="checkbox"/> Stage IV 4			
Medical/Nursing Needs			
Based on client's overall condition, assessor should evaluate medical and/or nursing needs.			
Are there ongoing medical/nursing needs? No 0 Yes 1			
If yes, describe ongoing medical/nursing needs:			
1. Evidence of medical instability. 2. Need for observation/assessment to prevent destabilization. 3. Complexity created by multiple medical conditions. 4. Why client's condition requires a physician, RN, or trained nurse's aide to oversee care on a daily basis.			
Comments:			
Optional: Physician's Signature: _____ Date: _____		Others: _____ Date: _____	
_____ (Signature/Title)			

Client Name: _____		Client SSN: _____	
4 PSYCHO - SOCIAL ASSESSMENT			
Cognitive Functions			
Orientation (Note: Information in italics is optional and can be used to give a MMSE Score in the box to the right.)			
Person: Please tell me your full name (so that I can make sure our record is correct).			
Place: Where are we now (state, county, town, street/route number, street name/box number)? Give the client 1 point for each correct response.			
Time: Would you tell me the date today (year, season, date, day, month)?			
<input type="checkbox"/> Oriented 0 <input type="checkbox"/> Disoriented - Some spheres, some of the time 1 <input type="checkbox"/> Disoriented - Some spheres, all the time 2 <input type="checkbox"/> Disoriented - All spheres, some of the time 3 <input type="checkbox"/> Disoriented - All spheres, all of the time 4 <input type="checkbox"/> Comatose 5	Spheres affected: _____		
Recall/Memory/Judgement			
Recall: I am going to say three words, and I want you to repeat them after I am done (House, Bus, Dog). Ask the client to repeat them. Give the client 1 point for each correct response on the first trial. Repeat up to 6 trials until client can name all 3 words. Tell the client to hold them in his mind because you will ask him again in a minute or so what they are.			
Attention/Concentration: Spell the word "WORLD". Then ask the client to spell it backwards. Give 1 point for each correctly placed letter (DLROW).			
Short-Term: Ask the client to recall the 3 words he was to remember.			
Long-Term: When were you born (What is your date of birth)?			
Judgement: If you needed help at night, what would you do?			
No 0 Yes 1 <input type="checkbox"/> Short-Term Memory Loss? <input type="checkbox"/> Long-Term Memory Loss? <input type="checkbox"/> Judgement Problem?			
Behavior Patterns			
Does the client ever wander without purpose (trespass, get lost, go into traffic, etc.) or become agitated and abusive?			
<input type="checkbox"/> Appropriate 0 <input type="checkbox"/> Wandering/Passive - Less than weekly 1 <input type="checkbox"/> Wandering/Passive - Weekly or more 2 <input type="checkbox"/> Abusive/Aggressive/Disruptive - Less than weekly 3 <input type="checkbox"/> Abusive/Aggressive/Disruptive - Weekly or more 4 <input type="checkbox"/> Comatose 5			
Type of inappropriate behavior: _____		Source of Information: _____	
Life Stressors			
Are there any stressful events that currently affect your life, such as...?			
No 0 Yes 1 <input type="checkbox"/> Change in work/employment <input type="checkbox"/> Death of someone close	No 0 Yes 1 <input type="checkbox"/> Financial problems <input type="checkbox"/> Major illness - family/friend	No 0 Yes 1 <input type="checkbox"/> Victim of a crime <input type="checkbox"/> Failing health	

Optional: MMSE Score

0

0

0

0

Total:

Note: Score of 14 or below implies cognitive impairment

Client NAME:		Client SSN:				
Emotional Status						
In the past month, how often did you...?	Rarely/ Never 0	Some of the Time 1	Often 2	Most of the Time 3	Unable Assess	
Feel anxious or worry constantly about things?						
Feel irritable, have crying spells or get upset over little things?						
Feel alone and that you didn't have anyone to talk to?						
Feel like you didn't want to be around other people?						
Feel afraid that something bad was going to happen to you and/or feel that others were trying to take things from you or trying to harm you?						
Feel sad or hopeless?						
Feel that life is not worth living... or think of taking your life?						
See or hear things that other people did not see or hear?						
Believe that you have special powers that others do not have?						
Have problems falling or staying asleep?						
Have problems with your appetite... that is, eat too much or too little?						

Comments:

Social Status	
Are there some things that you do that you especially enjoy?	
No 0 Yes 1	Describe
_____	Solitary Activities, _____
_____	With Friends/Family, _____
_____	With Groups/Clubs, _____
_____	Religious Activities, _____

How often do you talk with your children, family or friends, either during a visit or over the phone?		
Children	Other Family	Friends/Neighbors
_____ No Children 0	_____ No Other Family 0	_____ No Friends/Neighbors
_____ Daily 1	_____ Daily 1	_____ Daily 1
_____ Weekly 2	_____ Weekly 2	_____ Weekly 1
_____ Monthly 3	_____ Monthly 3	_____ Monthly 3
_____ Less than Monthly 4	_____ Less than Monthly 4	_____ Less than Monthly 4
_____ Never 5	_____ Never 5	_____ Never 5

Are you satisfied with how often you see or hear from your children, other family and/or friends?

_____ No 0 _____ Yes 1

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Client NAME:		Client SSN:	
Hospitalization/Alcohol-Drug Use			
Have you been hospitalized or received inpatient/outpatient treatment in the last 2 years for nerves, emotional/mental health, alcohol or substance abuse problems?			
_____ No 0 _____ Yes 1			
Name of Place	Admit Date	Length of Stay/Reason	

Do (did) you ever drink alcoholic beverages?

_____ Never 0
 _____ At one time, but no longer 1
 _____ Currently 2
 How much: _____
 How often: _____

Do (did) you ever use non-prescription, mood altering substances?

_____ Never 0
 _____ At one time, but no longer 1
 _____ Currently 2
 How much: _____
 How often: _____

If the client has never used alcohol or other non-prescription, mood altering substances, skip to the tobacco question.

Have you, or someone close to you, ever been concerned about your use of alcohol/other mood altering substances?	Do (did) you ever use alcohol/other mood-altering substances with...	Do (did) you ever use alcohol/other mood-altering substances to help you...
_____ No 0 _____ Yes 1	No 0 Yes 1	No 0 Yes 1
Describe concerns: _____	_____ Prescription drugs?	_____ Sleep?
_____	_____ OTC medicine?	_____ Relax?
_____	_____ Other substances?	_____ Get more energy?
_____	Describe what and how often: _____	_____ Relieve worries?
_____	_____	_____ Relieve physical pain?
_____	_____	Describe what and how often: _____

Do (did) you ever smoke or use tobacco products?

_____ Never 0
 _____ At one time, but no longer 1
 _____ Currently 2
 How much: _____
 How often: _____

Is there anything we have not talked about that you would like to discuss?

CLIENT NAME: _____ Client SSN: _____

5 ASSESSMENT SUMMARY

Indicators of Adult Abuse and Neglect: While completing the assessment, if you suspect abuse, neglect or exploitation, you are required by Virginia law, Section 63.1 - 55.3 to report this to the local Department of Social Services, Adult Protective Services.

Caregiver Assessment

Does the client have an informal caregiver?

___ No 0 (Skip to Section on Preferences) ___ Yes 1

Where does the caregiver live?

___ With client 0
___ Separate residence, close proximity 1
___ Separate residence, over 1 hour away 2

Is the caregiver's help ...

___ Adequate to meet the client's needs? 0
___ Not adequate to meet the client's needs? 1

Has providing care to the client become a burden for the caregiver?

___ Not at all 0
___ Somewhat 1
___ Very much 2

Describe any problems with continued caregiving:

Preferences

Client's preferences for receiving needed care: _____

Family/Representative's preferences for client's care: _____

Physician's comments (if applicable): _____

CLIENT NAME: _____ Client SSN: _____

Client Case Summary

Unmet Needs

No 0 Yes 1 (Check All That Apply)

___ Finances
___ Home/Physical Environment
___ ADLS
___ IADLS

No 0 Yes 1 (Check All That Apply)

___ Assistive Devices/Medical Equipment
___ Medical Care/Health
___ Nutrition
___ Cognitive/Emotional
___ Caregiver Support

Assessment Completed By

Assessor's Name	Signature	Agency/Provider Name	Provider #	Section(s) Completed

Optional: Case assigned to: _____ Code #: _____

* * * * *

Title of Regulation: State Plan for Medical Assistance Relating to Organ Transplantation.

VR 460-03-3.1100. Amount, Duration and Scope of Services (Supplement 1 to Attachment 3.1 A&B).

VR 460-02-3.1500. Standards for the Coverage of Organ Transplant Services.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Effective Date: July 14, 1994.

Summary:

Medicaid's transplant policy prior to the implementation of the emergency regulation limited coverage to cornea and kidney transplantation only. This policy became effective February 1989 following an extensive study by the Board of Medical Assistance Services (BMAS) of transplantation issues.

In March 1992 BMAS, at the request of the Secretary of Health and Human Services, undertook a study of coverage of transplantation services by the Virginia Medicaid program. Transplantation is a rapidly transforming area of medicine in which the efficacy of procedures, as well as the procedures themselves, are continually evolving. The board periodically reviews transplant coverage to ensure that medically appropriate care is available and accessible to Medicaid recipients.

In conducting its study, BMAS reviewed current literature to evaluate the status of organ and tissue transplantation for end stage renal, liver, lung, heart, and other diseases. Its inquiry included consideration of medical effectiveness, outcomes and survival rates, organ procurement, costs and financing, and ethical and social issues. It also examined the practices among other third party payers in terms of coverage and reimbursement.

BMAS also invited experts knowledgeable about transplantation issues to testify before it. Those making presentations included bio-medical ethicists, the director of the federal office of organ transplantation, organ procurement specialists, policy experts in the field of transplantation and its coverage, and physicians specializing in transplant procedures. Additionally, BMAS contacted all of the Commonwealth's medical facilities that perform organ transplants to solicit their input. These facilities were extremely responsive in meeting with BMAS and providing information and recommendations. In August 1992, BMAS conducted four public hearings throughout the Commonwealth for the purpose of giving the public the opportunity to comment regarding Medicaid coverage of transplantation. Sixteen people made presentations at these hearings.

Additionally, on June 24, 1993, the decision in *Pereira v. Kozlowski* (CA-92-255) (4th Circuit, 1993) required the Virginia Medicaid program to provide coverage of transplantation services for children under 21 according to the requirements of the Early Periodic Screening, Diagnosis, and Treatment Program.

On July 9, 1993, BMAS acted to adopt the recommendations of its study which would amend the present coverage policy. Coverage of transplantation will be continued for cornea and kidney. Coverage will be expanded, for children (under age 21) only, to liver, heart, and bone marrow (both autologous and allogeneic) transplantation and any other medically necessary transplant procedure that is not experimental or investigational.

Federal law requires that, in order to receive federal matching funds, states specify in their Medicaid State Plans any transplant procedures that are covered. Criteria for patient and facility selection for transplantation procedures must also be incorporated in the State Plan.

Summary of Public Comment and Agency Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the Office of the Registrar of Regulations.

Agency Contact: Copies of the regulation may be obtained from Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219, telephone (804) 371-8850. There may be a charge for copies.

VR 460-03-3.1100. Amount, Duration and Scope of Services.

General.

The provision of the following services cannot be reimbursed except when they are ordered or prescribed, and directed or performed within the scope of the license of a practitioner of the healing arts: laboratory and x-ray services, family planning services, and home health services. Physical therapy services will be reimbursed only when prescribed by a physician.

§ 1. Inpatient hospital services other than those provided in an institution for mental diseases.

A. Medicaid inpatient hospital admissions (lengths-of-stay) are limited to the 75th percentile of PAS (Professional Activity Study of the Commission on Professional and Hospital Activities) diagnostic/procedure limits. For admissions under 15 days that exceed the 75th percentile, the hospital must attach medical justification records to the billing invoice to be considered for additional coverage when medically justified. For all admissions that exceed 14 days up to a maximum of 21 days, the hospital must

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attach medical justification records to the billing invoice. (See the exception to subsection F of this section.)

B. Medicaid does not pay the medicare (Title XVIII) coinsurance for hospital care after 21 days regardless of the length-of-stay covered by the other insurance. (See exception to subsection F of this section.)

C. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment to health or life of the mother if the fetus were carried to term.

D. Reimbursement for covered hospital days is limited to one day prior to surgery, unless medically justified. Hospital claims with an admission date more than one day prior to the first surgical date will pend for review by medical staff to determine appropriate medical justification. The hospital must write on or attach the justification to the billing invoice for consideration of reimbursement for additional preoperative days. Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admissions will be denied.

E. Reimbursement will not be provided for weekend (Friday/Saturday) admissions, unless medically justified. Hospital claims with admission dates on Friday or Saturday will be pended for review by medical staff to determine appropriate medical justification for these days. The hospital must write on or attach the justification to the billing invoice for consideration of reimbursement coverage for these days. Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admissions will be denied.

F. Coverage of inpatient hospitalization will be limited to a total of 21 days for all admissions within a fixed period, which would begin with the first day inpatient hospital services are furnished to an eligible recipient and end 60 days from the day of the first admission. There may be multiple admissions during this 60-day period; however, when total days exceed 21, all subsequent claims will be reviewed. Claims which exceed 21 days within 60 days with a different diagnosis and medical justification will be paid. Any claim which has the same or similar diagnosis will be denied.

EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination. Medical documentation justifying admission and the continued

length of stay must be attached to or written on the invoice for review by medical staff to determine medical necessity. Medically unjustified days in such admissions will be denied.

G. Repealed.

H. Reimbursement will not be provided for inpatient hospitalization for those surgical and diagnostic procedures listed on the mandatory outpatient surgery list unless the inpatient stay is medically justified or meets one of the exceptions. The requirements for mandatory outpatient surgery do not apply to recipients in the retroactive eligibility period.

I. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. ~~Coverage of transplant services for all eligible persons is limited to transplants for kidneys and corneas. Transplant services for kidneys and corneas shall be covered for all eligible persons. Transplant services for liver, heart, and bone marrow transplantation and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, and bone marrow transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require preauthorization. Cornea transplants do not require preauthorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. The amount of reimbursement for covered kidney transplant services is negotiable with the providers on an individual case basis. Reimbursement for covered liver, heart, and bone marrow transplant services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be based upon a rate negotiated with providers on an individual case basis, or a flat rate by procedure, or by procedure and facility. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in Attachment 3.1 E.~~

J. The department may exempt portions or all of the utilization review documentation requirements of subsections A, D, E, F as it pertains to recipients under age 21, G, or H in writing for specific hospitals from time to time as part of their ongoing hospital utilization review performance evaluation. These exemptions are based on utilization review performance and review edit criteria which determine an individual hospital's review status as specified in the hospital provider manual. In compliance with federal regulations at 42 CFR 441.200, Subparts E and F, claims for hospitalization in which sterilization, hysterectomy or abortion procedures were performed, shall be subject to medical documentation requirements.

K. Hospitals qualifying for an exemption of all

documentation requirements except as described in subsection J above shall be granted "delegated review status" and shall, while the exemption remains in effect, not be required to submit medical documentation to support pended claims on a prepayment hospital utilization review basis to the extent allowed by federal or state law or regulation. The following audit conditions apply to delegated review status for hospitals:

1. The department shall conduct periodic on-site post-payment audits of qualifying hospitals using a statistically valid sampling of paid claims for the purpose of reviewing the medical necessity of inpatient stays.
2. The hospital shall make all medical records of which medical reviews will be necessary available upon request, and shall provide an appropriate place for the department's auditors to conduct such review.
3. The qualifying hospital will immediately refund to the department in accordance with § 32.1-325.1 A and B of the Code of Virginia the full amount of any initial overpayment identified during such audit.
4. The hospital may appeal adverse medical necessity and overpayment decisions pursuant to the current administrative process for appeals of post-payment review decisions.
5. The department may, at its option, depending on the utilization review performance determined by an audit based on criteria set forth in the hospital provider manual, remove a hospital from delegated review status and reapply certain or all prepayment utilization review documentation requirements.

§ 2. Outpatient hospital and rural health clinic services.

2a. Outpatient hospital services.

A. Outpatient hospital services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that:

1. Are furnished to outpatients;
2. Except in the case of nurse-midwife services, as specified in § 440.165, are furnished by or under the direction of a physician or dentist; and
3. Are furnished by an institution that:
 - a. Is licensed or formally approved as a hospital by an officially designated authority for state standard-setting; and
 - b. Except in the case of medical supervision of nurse-midwife services, as specified in § 440.165, meets the requirements for participation in Medicare.

B. Reimbursement for induced abortions is provided in only those cases in which there would be substantial endangerment of health or life to the mother if the fetus were carried to term.

C. Reimbursement will not be provided for outpatient hospital services for any selected elective surgical procedures that require a second surgical opinion unless a properly executed second surgical opinion form has been obtained from the physician and submitted with the invoice for payment, or is a justified emergency or exemption.

2b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

The same service limitations apply to rural health clinics as to all other services.

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with § 4231 of the State Medicaid Manual (HCFA Pub. 45-4).

The same service limitations apply to FQHCs as to all other services.

§ 3. Other laboratory and x-ray services.

Service must be ordered or prescribed and directed or performed within the scope of a license of the practitioner of the healing arts.

§ 4. Skilled nursing facility services, EPSDT and family planning.

4a. Skilled nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Service must be ordered or prescribed and directed or performed within the scope of a license of the practitioner of the healing arts.

4b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

A. Payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities, and the accompanying attendant physician care, in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination.

B. Routine physicals and immunizations (except as provided through EPSDT) are not covered except that well-child examinations in a private physician's office are covered for foster children of the local social services

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departments on specific referral from those departments.

C. Orthoptics services shall only be reimbursed if medically necessary to correct a visual defect identified by an EPSDT examination or evaluation. The department shall place appropriate utilization controls upon this service.

D. Consistent with the Omnibus Budget Reconciliation Act of 1989 § 6403, early and periodic screening, diagnostic, and treatment services means the following services: screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in the Social Security Act § 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services and which are medically necessary, whether or not such services are covered under the State Plan and notwithstanding the limitations, applicable to recipients ages 21 and over, provided for by the Act § 1905(a).

4c. Family planning services and supplies for individuals of child-bearing age.

A. Service must be ordered or prescribed and directed or performed within the scope of the license of a practitioner of the healing arts.

B. Family planning services shall be defined as those services which delay or prevent pregnancy. Coverage of such services shall not include services to treat infertility nor services to promote fertility.

§ 5. Physician's services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.

A. Elective surgery as defined by the Program is surgery that is not medically necessary to restore or materially improve a body function.

B. Cosmetic surgical procedures are not covered unless performed for physiological reasons and require Program prior approval.

C. Routine physicals and immunizations are not covered except when the services are provided under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program and when a well-child examination is performed in a private physician's office for a foster child of the local social services department on specific referral from those departments.

D. Psychiatric services are limited to an initial availability of 26 sessions, with one possible extension (subject to the approval of the Psychiatric Review Board) of 26 sessions during the first year of treatment. The availability is further restricted to no more than 26 sessions each succeeding year when approved by the Psychiatric Review Board. Psychiatric services are further

restricted to no more than three sessions in any given seven-day period. These limitations also apply to psychotherapy sessions by clinical psychologists licensed by the State Board of Medicine and psychologists clinical licensed by the Board of Psychology.

E. Any procedure considered experimental is not covered.

F. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment of health or life to the mother if the fetus were carried to term.

G. Physician visits to inpatient hospital patients are limited to a maximum of 21 days per admission within 60 days for the same or similar diagnoses and is further restricted to medically necessary inpatient hospital days as determined by the Program.

EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination. Payments for physician visits for inpatient days determined to be medically unjustified will be adjusted.

H. Psychological testing and psychotherapy by clinical psychologists licensed by the State Board of Medicine and psychologists clinical licensed by the Board of Psychology are covered.

I. Repealed.

J. Reimbursement will not be provided for physician services performed in the inpatient setting for those surgical or diagnostic procedures listed on the mandatory outpatient surgery list unless the service is medically justified or meets one of the exceptions. The requirements of mandatory outpatient surgery do not apply to recipients in a retroactive eligibility period.

K. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. *Coverage of transplant services for all eligible persons is limited to transplants for kidneys and corneas. Transplant services for kidneys and corneas shall be covered for all eligible persons. Transplant services for liver, heart, and bone marrow and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, and bone marrow transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require preauthorization. Cornea transplants do not require preauthorization. The*

patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. ~~The amount of reimbursement for covered kidney transplant services is negotiable with the providers on an individual case basis.~~ *Reimbursement for covered liver, heart, and bone marrow transplant services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be based upon a rate negotiated with providers on an individual case basis, or a flat rate by procedure, or by procedure and facility.* Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in Attachment 3.1 E.

§ 6. Medical care by other licensed practitioners within the scope of their practice as defined by state law.

A. Podiatrists' services.

1. Covered podiatry services are defined as reasonable and necessary diagnostic, medical, or surgical treatment of disease, injury, or defects of the human foot. These services must be within the scope of the license of the podiatrists' profession and defined by state law.

2. The following services are not covered: preventive health care, including routine foot care; treatment of structural misalignment not requiring surgery; cutting or removal of corns, warts, or calluses; experimental procedures; acupuncture.

3. The Program may place appropriate limits on a service based on medical necessity or for utilization control, or both.

B. Optometrists' services.

Diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians, as allowed by the Code of Virginia and by regulations of the Boards of Medicine and Optometry, are covered for all recipients. Routine refractions are limited to once in 24 months except as may be authorized by the agency.

C. Chiropractors' services.

Not provided.

D. Other practitioners' services.

1. Clinical psychologists' services.

a. These limitations apply to psychotherapy sessions by clinical psychologists licensed by the State Board of Medicine and psychologists clinical licensed by the Board of Psychology. Psychiatric services are

limited to an initial availability of 26 sessions, with one possible extension of 26 sessions during the first year of treatment. The availability is further restricted to no more than 26 sessions each succeeding year when approved by the Psychiatric Review Board. Psychiatric services are further restricted to no more than three sessions in any given seven-day period.

b. Psychological testing and psychotherapy by clinical psychologists licensed by the State Board of Medicine and psychologists clinical licensed by the Board of Psychology are covered.

§ 7. Home health services.

A. Service must be ordered or prescribed and directed or performed within the scope of a license of a practitioner of the healing arts.

B. Nursing services provided by a home health agency.

1. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

2. Patients may receive up to 32 visits by a licensed nurse annually. Limits are per recipient, regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient. If services beyond these limitations are determined by the physician to be required, then the provider shall request prior authorization from DMAS for additional services. Payment shall not be made for additional service unless authorized by DMAS.

C. Home health aide services provided by a home health agency.

1. Home health aides must function under the supervision of a professional nurse.

2. Home health aides must meet the certification requirements specified in 42 CFR 484.36.

3. For home health aide services, patients may receive up to 32 visits annually. Limits shall be per recipient, regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient.

D. Medical supplies, equipment, and appliances suitable for use in the home.

1. All medically necessary supplies, equipment, and appliances are covered for patients of the home health agency. Unusual amounts, types, and duration of usage must be authorized by DMAS in accordance with published policies and procedures. When determined to be cost-effective by DMAS, payment may be made for rental of the equipment in lieu of

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purchase.

2. Medical supplies, equipment, and appliances for all others are limited to home renal dialysis equipment and supplies, respiratory equipment and oxygen, and ostomy supplies, as authorized by the agency.

3. Supplies, equipment, or appliances that are not covered include, but are not limited to, the following:

a. Space conditioning equipment, such as room humidifiers, air cleaners, and air conditioners.

b. Durable medical equipment and supplies for any hospital or nursing facility resident, except ventilators and associated supplies for nursing facility residents that have been approved by DMAS central office.

c. Furniture or appliances not defined as medical equipment (such as blenders, bedside tables, mattresses other than for a hospital bed, pillows, blankets or other bedding, special reading lamps, chairs with special lift seats, hand-held shower devices, exercise bicycles, and bathroom scales).

d. Items that are only for the recipient's comfort and convenience or for the convenience of those caring for the recipient (e.g., a hospital bed or mattress because the recipient does not have a decent bed; wheelchair trays used as a desk surface); mobility items used in addition to primary assistive mobility aide for caregiver's or recipient's convenience (i.e., electric wheelchair plus a manual chair); cleansing wipes.

e. Prosthesis, except for artificial arms, legs, and their supportive devices which must be preauthorized by the DMAS central office (effective July 1, 1989).

f. Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (for example, over-the-counter drugs; dentifrices; toilet articles; shampoos which do not require a physician's prescription; dental adhesives; electric toothbrushes; cosmetic items, soaps, and lotions which do not require a physician's prescription; sugar and salt substitutes; support stockings; and nonlegend drugs).

g. Orthotics, including braces, splints, and supports.

h. Home or vehicle modifications.

i. Items not suitable for or used primarily in the home setting (i.e., car seats, equipment to be used while at school, etc.).

j. Equipment that the primary function is

vocationally or educationally related (i.e., computers, environmental control devices, speech devices, etc.).

4. For coverage of blood glucose meters for pregnant women, refer to Supplement 3 to Attachments 3.1 A and B.

E. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

1. Service covered only as part of a physician's plan of care.

2. Patients may receive up to 24 visits for each rehabilitative therapy service ordered annually. Limits shall apply per recipient regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient. If services beyond these limitations are determined by the physician to be required, then the provider shall request prior authorization from DMAS for additional services.

§ 8. Private duty nursing services.

Not provided.

§ 9. Clinic services.

A. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment of health or life to the mother if the fetus was carried to term.

B. Clinic services means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that:

1. Are provided to outpatients;

2. Are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients; and

3. Except in the case of nurse-midwife services, as specified in 42 dentist.

§ 10. Dental services.

A. Dental services are limited to recipients under 21 years of age in fulfillment of the treatment requirements under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program and defined as routine diagnostic, preventive, or restorative procedures necessary for oral health provided by or under the direct supervision of a dentist in accordance with the State Dental Practice Act.

B. Initial, periodic, and emergency examinations; required radiography necessary to develop a treatment

plan; patient education; dental prophylaxis; fluoride treatments; dental sealants; routine amalgam and composite restorations; crown recementation; pulpotomies; emergency endodontics for temporary relief of pain; pulp capping; sedative fillings; therapeutic apical closure; topical palliative treatment for dental pain; removal of foreign body; simple extractions; root recovery; incision and drainage of abscess; surgical exposure of the tooth to aid eruption; sequestrectomy for osteomyelitis; and oral antral fistula closure are dental services covered without preauthorization by the state agency.

C. All covered dental services not referenced above require preauthorization by the state agency. The following services are also covered through preauthorization: medically necessary full banded orthodontics, for handicapping malocclusions, minor tooth guidance or repositioning appliances, complete and partial dentures, surgical preparation (alveoloplasty) for prosthetics, single permanent crowns, and bridges. The following service is not covered: routine bases under restorations.

D. The state agency may place appropriate limits on a service based on medical necessity, for utilization control, or both. Examples of service limitations are: examinations, prophylaxis, fluoride treatment (once/six months); space maintenance appliances; bitewing x-ray — two films (once/12 months); routine amalgam and composite restorations (once/three years); dentures (once per 5 years); extractions, orthodontics, tooth guidance appliances, permanent crowns, and bridges, endodontics, patient education and sealants (once).

E. Limited oral surgery procedures, as defined and covered under Title XVIII (Medicare), are covered for all recipients, and also require preauthorization by the state agency.

§ 11. Physical therapy and related services.

Physical therapy and related services shall be defined as physical therapy, occupational therapy, and speech-language pathology services. These services shall be prescribed by a physician and be part of a written plan of care. Any one of these services may be offered as the sole service and shall not be contingent upon the provision of another service. All practitioners and providers of services shall be required to meet state and federal licensing and/or certification requirements.

11a. Physical therapy.

A. Services for individuals requiring physical therapy are provided only as an element of hospital inpatient or outpatient service, nursing facility service, home health service, services provided by a local school division employing qualified therapists, or when otherwise included as an authorized service by a cost provider who provides rehabilitation services.

B. Effective July 1, 1988, the Program will not provide

direct reimbursement to enrolled providers for physical therapy service rendered to patients residing in long term care facilities. Reimbursement for these services is and continues to be included as a component of the nursing homes' operating cost.

C. Physical therapy services meeting all of the following conditions shall be furnished to patients:

1. Physical therapy services shall be directly and specifically related to an active written care plan designed by a physician after any needed consultation with a physical therapist licensed by the Board of Medicine;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a physical therapist licensed by the Board of Medicine, or a physical therapy assistant who is licensed by the Board of Medicine and is under the direct supervision of a physical therapist licensed by the Board of Medicine. When physical therapy services are provided by a qualified physical therapy assistant, such services shall be provided under the supervision of a qualified physical therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

11b. Occupational therapy.

A. Services for individuals requiring occupational therapy are provided only as an element of hospital inpatient or outpatient service, nursing facility service, home health service, services provided by a local school division employing qualified therapists, or when otherwise included as an authorized service by a cost provider who provides rehabilitation services.

B. Effective September 1, 1990, Virginia Medicaid will not make direct reimbursement to providers for occupational therapy services for Medicaid recipients residing in long-term care facilities. Reimbursement for these services is and continues to be included as a component of the nursing facilities' operating cost.

C. Occupational therapy services shall be those services furnished a patient which meet all of the following conditions:

1. Occupational therapy services shall be directly and specifically related to an active written care plan designed by a physician after any needed consultation with an occupational therapist registered and certified by the American Occupational Therapy Certification

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Board.

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by an occupational therapist registered and certified by the American Occupational Therapy Certification Board, a graduate of a program approved by the Council on Medical Education of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association when under the supervision of an occupational therapist defined above, or an occupational therapy assistant who is certified by the American Occupational Therapy Certification Board under the direct supervision of an occupational therapist as defined above. When occupational therapy services are provided by a qualified occupational therapy assistant or a graduate engaged in supplemental clinical experience required before registration, such services shall be provided under the supervision of a qualified occupational therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

11c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist; see Page 1, General and Page 12, Physical Therapy and Related Services.)

A. These services are provided by or under the supervision of a speech pathologist or an audiologist only as an element of hospital inpatient or outpatient service, nursing facility service, home health service, services provided by a local school division employing qualified therapists, or when otherwise included as an authorized service by a cost provider who provides rehabilitation services.

B. Effective September 1, 1990, Virginia Medicaid will not make direct reimbursement to providers for speech-language pathology services for Medicaid recipients residing in long-term care facilities. Reimbursement for these services is and continues to be included as a component of the nursing facilities' operating cost.

C. Speech-language pathology services shall be those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a speech-language pathologist licensed by the Board of

Audiology and Speech-Language Pathology, or, if exempted from licensure by statute, meeting the requirements in 42 CFR 440.110(c);

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by or under the direction of a speech-language pathologist who meets the qualifications in number 1. The program shall meet the requirements of 42 CFR 405.1719(c). At least one qualified speech-language pathologist must be present at all times when speech-language pathology services are rendered; and

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

11d. Authorization for services.

A. Physical therapy, occupational therapy, and speech-language pathology services provided in outpatient settings of acute and rehabilitation hospitals, rehabilitation agencies, or home health agencies shall include authorization for up to 24 visits by each ordered rehabilitative service within a 60-day period. A recipient may receive a maximum of 48 visits annually without authorization. The provider shall maintain documentation to justify the need for services.

B. The provider shall request from DMAS authorization for treatments deemed necessary by a physician beyond the number authorized. This request must be signed and dated by a physician. Authorization for extended services shall be based on individual need. Payment shall not be made for additional service unless the extended provision of services has been authorized by DMAS.

11e. Documentation requirements.

A. Documentation of physical therapy, occupational therapy, and speech-language pathology services provided by a hospital-based outpatient setting, home health agency, a school division, or a rehabilitation agency shall, at a minimum:

1. Describe the clinical signs and symptoms of the patient's condition;

2. Include an accurate and complete chronological picture of the patient's clinical course and treatments;

3. Document that a plan of care specifically designed for the patient has been developed based upon a comprehensive assessment of the patient's needs;

4. Include a copy of the physician's orders and plan of care;

5. Include all treatment rendered to the patient in accordance with the plan with specific attention to frequency, duration, modality, response, and identify who provided care (include full name and title);

6. Describe changes in each patient's condition and response to the rehabilitative treatment plan;

7. (Except for school divisions) describe a discharge plan which includes the anticipated improvements in functional levels, the time frames necessary to meet these goals, and the patient's discharge destination; and

8. In school divisions, include an individualized education program (IEP) which describes the anticipated improvements in functional level in each school year and the time frames necessary to meet these goals.

B. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

11f. Service limitations. The following general conditions shall apply to reimbursable physical therapy, occupational therapy, and speech-language pathology:

A. Patient must be under the care of a physician who is legally authorized to practice and who is acting within the scope of his license.

B. Services shall be furnished under a written plan of treatment and must be established and periodically reviewed by a physician. The requested services or items must be necessary to carry out the plan of treatment and must be related to the patient's condition.

C. A physician recertification shall be required periodically, must be signed and dated by the physician who reviews the plan of treatment, and may be obtained when the plan of treatment is reviewed. The physician recertification statement must indicate the continuing need for services and should estimate how long rehabilitative services will be needed.

D. The physician orders for therapy services shall include the specific procedures and modalities to be used, identify the specific discipline to carry out the plan of care, and indicate the frequency and duration for services.

E. Utilization review shall be performed to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

F. Physical therapy, occupational therapy and

speech-language services are to be terminated regardless of the approved length of stay when further progress toward the established rehabilitation goal is unlikely or when the services can be provided by someone other than the skilled rehabilitation professional.

§ 12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

12a. Prescribed drugs.

A. Drugs for which Federal Financial Participation is not available, pursuant to the requirements of § 1927 of the Social Security Act (OBRA '90 § 4401), shall not be covered except for over-the-counter drugs when prescribed for nursing facility residents.

B. The following prescribed, nonlegend drugs/drug devices shall be covered: (i) insulin, (ii) syringes, (iii) needles, (iv) diabetic test strips for clients under 21 years of age, (v) family planning supplies, and (vi) those prescribed to nursing home residents.

C. Legend drugs are covered, with the exception of anorexiants prescribed for weight loss and the drugs for classes of drugs identified in Supplement 5.

D. Notwithstanding the provisions of § 32.1-87 of the Code of Virginia, and in compliance with the provision of § 4401 of the Omnibus Reconciliation Act of 1990, § 1927(e) of the Social Security Act as amended by OBRA 90, and pursuant to the authority provided for under § 32.1-325 A of the Code of Virginia, prescriptions for Medicaid recipients for multiple source drugs subject to 42 CFR § 447.332 shall be filled with generic drug products unless the physician or other practitioners so licensed and certified to prescribe drugs certifies in his own handwriting "brand necessary" for the prescription to be dispensed as written.

E. New drugs shall be covered in accordance with the Social Security Act § 1927(d) (OBRA 90 § 4401).

F. The number of refills shall be limited pursuant to § 54.1-3411 of the Drug Control Act.

G. Drug prior authorization.

1. Definitions.

"Board" means the Board for Medical Assistance Services.

"Committee" means the Medicaid Prior Authorization Advisory Committee.

"Department" means the Department of Medical Assistance Services.

"Director" means the Director of Medical Assistance

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Services.

"Drug" shall have the same meaning, unless the context otherwise dictates or the Board otherwise provides by regulation, as provided in the Drug Control Act (§ 54.1-3400 et seq.)

2. Medicaid Prior Authorization Advisory Committee; membership. The Medicaid Prior Authorization Committee shall consist of 10 members to be appointed by the board. Five members shall be physicians, at least three of whom shall care for a significant number of Medicaid patients; four shall be pharmacists, two of whom shall be community pharmacists; and one shall be a Medicaid recipient.

a. A quorum for action by the committee shall consist of six members.

b. The members shall serve at the pleasure of the board; vacancies shall be filled in the same manner as the original appointment.

c. The board shall consider nominations made by the Medical Society of Virginia, the Old Dominion Medical Society and the Virginia Pharmaceutical Association when making appointments to the committee.

d. The committee shall elect its own officers, establish its own procedural rules, and meet as needed or as called by the board, the director, or any two members of the committee. The department shall provide appropriate staffing to the committee.

3. Duties of the committee.

a. The committee shall make recommendations to the board regarding drugs or categories of drugs to be subject to prior authorization, prior authorization requirements for prescription drug coverage and any subsequent amendments to or revisions of the prior authorization requirements. The board may accept or reject the recommendations in whole or in part, and may amend or add to the recommendations, except that the board may not add to the recommendation of drugs and categories of drugs to be subject to prior authorization.

b. In formulating its recommendations to the board, the committee shall not be deemed to be formulating regulations for the purposes of the Administrative Process Act (§ 9-6.14:1 et seq.). The committee shall, however, conduct public hearings prior to making recommendations to the board. The committee shall give 30 days written notice by mail of the time and place of its hearings and meetings to any manufacturer whose product is being reviewed by the committee and to those manufacturers who request of the committee in writing that they be informed of such hearings and

meetings. These persons shall be afforded a reasonable opportunity to be heard and present information. The committee shall give 30 days notice of such public hearings to the public by publishing its intention to conduct hearings and meetings in the Calendar of Events of The Virginia Register of Regulations and a newspaper of general circulation located in Richmond.

c. In acting on the recommendations of the committee, the board shall conduct further proceedings under the Administrative Process Act.

4. Prior authorization of prescription drug products, coverage.

a. The committee shall review prescription drug products to recommend prior authorization under the state plan. This review may be initiated by the director, the committee itself, or by written request of the board. The committee shall complete its recommendations to the board within no more than six months from receipt of any such request.

b. Coverage for any drug requiring prior authorization shall not be approved unless a prescribing physician obtains prior approval of the use in accordance with regulations promulgated by the board and procedures established by the department.

c. In formulating its recommendations to the board, the committee shall consider the potential impact on patient care and the potential fiscal impact of prior authorization on pharmacy, physician, hospitalization and outpatient costs. Any proposed regulation making a drug or category of drugs subject to prior authorization shall be accompanied by a statement of the estimated impact of this action on pharmacy, physician, hospitalization and outpatient costs.

d. The committee shall not review any drug for which it has recommended or the board has required prior authorization within the previous 12 months, unless new or previously unavailable relevant and objective information is presented.

e. Confidential proprietary information identified as such by a manufacturer or supplier in writing in advance and furnished to the committee or the board according to this subsection shall not be subject to the disclosure requirements of the Virginia Freedom of Information Act (§ 2.1-340 et seq.). The board shall establish by regulation the means by which such confidential proprietary information shall be protected.

5. Immunity. The members of the committee and the board and the staff of the department shall be immune, individually and jointly, from civil liability for any act, decision, or omission done or made in

performance of their duties pursuant to this subsection while serving as a member of such board, committee, or staff provided that such act, decision, or omission is not done or made in bad faith or with malicious intent.

6. Annual report to joint commission. The committee shall report annually to the Joint Commission on Health Care regarding its recommendations for prior authorization of drug products.

12b. Dentures.

Provided only as a result of EPSDT and subject to medical necessity and preauthorization requirements specified under Dental Services.

12c. Prosthetic devices.

A. Prosthetics services shall mean the replacement of missing arms and legs. Nothing in this regulation shall be construed to refer to orthotic services or devices.

B. Prosthetic devices (artificial arms and legs, and their necessary supportive attachments) are provided when prescribed by a physician or other licensed practitioner of the healing arts within the scope of their professional licenses as defined by state law. This service, when provided by an authorized vendor, must be medically necessary, and preauthorized for the minimum applicable component necessary for the activities of daily living.

12d. Eyeglasses.

Eyeglasses shall be reimbursed for all recipients younger than 21 years of age according to medical necessity when provided by practitioners as licensed under the Code of Virginia.

§ 13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13a. Diagnostic services.

Not provided.

13b. Screening services.

Screening mammograms for the female recipient population aged 35 and over shall be covered, consistent with the guidelines published by the American Cancer Society.

13c. Preventive services.

Not provided.

13d. Rehabilitative services.

A. Intensive physical rehabilitation.

1. Medicaid covers intensive inpatient rehabilitation services as defined in subdivision A 4 in facilities certified as rehabilitation hospitals or rehabilitation units in acute care hospitals which have been certified by the Department of Health to meet the requirements to be excluded from the Medicare Prospective Payment System.

2. Medicaid covers intensive outpatient physical rehabilitation services as defined in subdivision A 4 in facilities which are certified as Comprehensive Outpatient Rehabilitation Facilities (CORFs).

3. These facilities are excluded from the 21-day limit otherwise applicable to inpatient hospital services. Cost reimbursement principles are defined in Attachment 4.19-A.

4. An intensive rehabilitation program provides intensive skilled rehabilitation nursing, physical therapy, occupational therapy, and, if needed, speech therapy, cognitive rehabilitation, prosthetic-orthotic services, psychology, social work, and therapeutic recreation. The nursing staff must support the other disciplines in carrying out the activities of daily living, utilizing correctly the training received in therapy and furnishing other needed nursing services. The day-to-day activities must be carried out under the continuing direct supervision of a physician with special training or experience in the field of rehabilitation.

5. Nothing in this regulation is intended to preclude DMAS from negotiating individual contracts with in-state intensive physical rehabilitation facilities for those individuals with special intensive rehabilitation needs.

B. Community mental health services.

Definitions. The following words and terms, when used in these regulations, shall have the following meanings unless the context clearly indicates otherwise:

"Code" means the Code of Virginia.

"DMAS" means the Department of Medical Assistance Services consistent with Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 of the Code of Virginia.

"DMHMRSAS" means Department of Mental Health, Mental Retardation and Substance Abuse Services consistent with Chapter 1 (§ 37.1-39 et seq.) of Title 37.1 of the Code of Virginia.

1. Mental health services. The following services, with their definitions, shall be covered:

a. Intensive in-home services for children and adolescents under age 21 shall be time-limited interventions provided typically but not solely in the

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residence of an individual who is at risk of being moved into an out-of-home placement or who is being transitioned to home from out-of-home placement due to a disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders-III-R (DSM-III-R). These services provide crisis treatment; individual and family counseling; life (e.g., counseling to assist parents to understand and practice proper child nutrition, child health care, personal hygiene, and financial management, etc.), parenting (e.g., counseling to assist parents to understand and practice proper nurturing and discipline, and behavior management, etc.), and communication skills (e.g., counseling to assist parents to understand and practice appropriate problem-solving, anger management, and interpersonal interaction, etc.); case management activities and coordination with other required services; and 24-hour emergency response. These services shall be limited annually to 26 weeks.

b. Therapeutic day treatment for children and adolescents shall be provided in sessions of two or more hours per day, to groups of seriously emotionally disturbed children and adolescents or children at risk of serious emotional disturbance in order to provide therapeutic interventions. Day treatment programs, limited annually to 780 units, provide evaluation, medication education and management, opportunities to learn and use daily living skills and to enhance social and interpersonal skills (e.g., problem solving, anger management, community responsibility, increased impulse control and appropriate peer relations, etc.), and individual, group and family counseling.

c. Day treatment/partial hospitalization services for adults shall be provided in sessions of two or more consecutive hours per day, which may be scheduled multiple times per week, to groups of individuals in a nonresidential setting. These services, limited annually to 780 units, include the major diagnostic, medical, psychiatric, psychosocial and psychoeducational treatment modalities designed for individuals with serious mental disorders who require coordinated, intensive, comprehensive, and multidisciplinary treatment.

d. Psychosocial rehabilitation for adults shall be provided in sessions of two or more consecutive hours per day to groups of individuals in a nonresidential setting. These services, limited annually to 936 units, include assessment, medication education, psychoeducation, opportunities to learn and use independent living skills and to enhance social and interpersonal skills, family support, and education within a supportive and normalizing program structure and environment.

e. Crisis intervention shall provide immediate mental health care, available 24 hours a day, seven days

per week, to assist individuals who are experiencing acute mental dysfunction requiring immediate clinical attention. This service's objectives shall be to prevent exacerbation of a condition, to prevent injury to the client or others, and to provide treatment in the context of the least restrictive setting. Crisis intervention activities, limited annually to 180 hours, shall include assessing the crisis situation, providing short-term counseling designed to stabilize the individual or the family unit or both, providing access to further immediate assessment and follow-up, and linking the individual and family with ongoing care to prevent future crises. Crisis intervention services may include, but are not limited to, office visits, home visits, preadmission screenings, telephone contacts, and other client-related activities for the prevention of institutionalization.

2. Mental retardation services. Day health and rehabilitation services shall be covered and the following definitions shall apply:

Day health and rehabilitation services (limited to 780 units per year) shall provide individualized activities, supports, training, supervision, and transportation based on a written plan of care to eligible persons for two or more hours per day scheduled multiple times per week. These services are intended to improve the recipient's condition or to maintain an optimal level of functioning, as well as to ameliorate the recipient's disabilities or deficits by reducing the degree of impairment or dependency. Therapeutic consultation to service providers, family, and friends of the client around implementation of the plan of care may be included as part of the services provided by the day health and rehabilitation program. The provider shall be licensed by DMHMRSAS as a Day Support Program. Specific components of day health and rehabilitation services include the following as needed:

- (1) Self-care and hygiene skills;
- (2) Eating and toilet training skills;
- (3) Task learning skills;
- (4) Community resource utilization skills (e.g., training in time, telephone, basic computations with money, warning sign recognition, and personal identifications, etc.);
- (5) Environmental and behavior skills (e.g., training in punctuality, self-discipline, care of personal belongings and respect for property and in wearing proper clothing for the weather, etc.);
- (6) Medication management;
- (7) Travel and related training to and from the

training sites and service and support activities;

(8) Skills related to the above areas, as appropriate that will enhance or retain the recipient's functioning.

§ 14. Services for individuals age 65 or older in institutions for mental diseases.

14a. Inpatient hospital services.

Provided, no limitations.

14b. Skilled nursing facility services.

Provided, no limitations.

14c. Intermediate care facility.

Provided, no limitations.

§ 15. Intermediate care services and intermediate care services for institutions for mental disease and mental retardation.

15a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with § 1902 (a)(31)(A) of the Act, to be in need of such care.

Provided, no limitations.

15b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

Provided, no limitations.

§ 16. Inpatient psychiatric facility services for individuals under 22 years of age.

Not provided.

§ 17. Nurse-midwife services.

Covered services for the nurse midwife are defined as those services allowed under the licensure requirements of the state statute and as specified in the Code of Federal Regulations, i.e., maternity cycle.

§ 18. Hospice care (in accordance with § 1905 (o) of the Act).

A. Covered hospice services shall be defined as those services allowed under the provisions of Medicare law and regulations as they relate to hospice benefits and as specified in the Code of Federal Regulations, Title 42, Part 418.

B. Categories of care.

As described for Medicare and applicable to Medicaid, hospice services shall entail the following four categories of daily care:

1. Routine home care is at-home care that is not continuous.

2. Continuous home care consists of at-home care that is predominantly nursing care and is provided as short-term crisis care. A registered or licensed practical nurse must provide care for more than half of the period of the care. Home health aide or homemaker services may be provided in addition to nursing care. A minimum of eight hours of care per day must be provided to qualify as continuous home care.

3. Inpatient respite care is short-term inpatient care provided in an approved facility (freestanding hospice, hospital, or nursing facility) to relieve the primary caregiver(s) providing at-home care for the recipient. Respite care is limited to not more than five consecutive days.

4. General inpatient care may be provided in an approved freestanding hospice, hospital, or nursing facility. This care is usually for pain control or acute or chronic symptom management which cannot be successfully treated in another setting.

C. Covered services.

1. As required under Medicare and applicable to Medicaid, the hospice itself shall provide all or substantially all of the "core" services applicable for the terminal illness which are nursing care, physician services, social work, and counseling (bereavement, dietary, and spiritual).

2. Other services applicable for the terminal illness that shall be available but are not considered "core" services are drugs and biologicals, home health aide and homemaker services, inpatient care, medical supplies, and occupational and physical therapies and speech-language pathology services.

3. These other services may be arranged, such as by contractual agreement, or provided directly by the hospice.

4. To be covered, a certification that the individual is terminally ill shall have been completed by the physician and hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. The individual must elect hospice care and a plan of care must be established before services are provided. To be covered, services shall be consistent with the plan of care. Services not specifically documented in the patient's medical record as having been rendered will be deemed not to have been rendered and no

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coverage will be provided.

5. All services shall be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service. The following services are covered hospice services:

a. Nursing care. Nursing care shall be provided by a registered nurse or by a licensed practical nurse under the supervision of a graduate of an approved school of professional nursing and who is licensed as a registered nurse.

b. Medical social services. Medical social services shall be provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.

c. Physician services. Physician services shall be performed by a professional who is licensed to practice, who is acting within the scope of his or her license, and who is a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor. The hospice medical director or the physician member of the interdisciplinary team shall be a licensed doctor of medicine or osteopathy.

d. Counseling services. Counseling services shall be provided to the terminally ill individual and the family members or other persons caring for the individual at home. Bereavement counseling consists of counseling services provided to the individual's family up to one year after the individual's death. Bereavement counseling is a required hospice service, but it is not reimbursable.

e. Short-term inpatient care. Short-term inpatient care may be provided in a participating hospice inpatient unit, or a participating hospital or nursing facility. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home.

f. Durable medical equipment and supplies. Durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness is covered. Medical supplies include those that are part of the written plan of care.

g. Drugs and biologicals. Only drugs used which are

used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered.

h. Home health aide and homemaker services. Home health aides providing services to hospice recipients must meet the qualifications specified for home health aides by 42 CFR 484.36. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care. Home health aide and homemaker services must be provided under the general supervision of a registered nurse.

i. Rehabilitation services. Rehabilitation services include physical and occupational therapies and speech-language pathology services that are used for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

D. Eligible groups.

To be eligible for hospice coverage under Medicare or Medicaid, the recipient must have a life expectancy of six months or less, have knowledge of the illness and life expectancy, and elect to receive hospice services rather than active treatment for the illness. Both the attending physician and the hospice medical director must certify the life expectancy. The hospice must obtain the certification that an individual is terminally ill in accordance with the following procedures:

1. For the first 90-day period of hospice coverage, the hospice must obtain, within two calendar days after the period begins, a written certification statement signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician if the individual has an attending physician. For the initial 90-day period, if the hospice cannot obtain written certifications within two calendar days, it must obtain oral certifications within two calendar days, and written certifications no later than eight calendar days after the period begins.

2. For any subsequent 90-day or 30-day period or a subsequent extension period during the individual's lifetime, the hospice must obtain, no later than two calendar days after the beginning of that period, a written certification statement prepared by the medical director of the hospice or the physician member of the hospice's interdisciplinary group. The certification must include the statement that the

individual's medical prognosis is that his or her life expectancy is six months or less and the signature(s) of the physician(s). The hospice must maintain the certification statements.

§ 19. Case management services for high-risk pregnant women and children up to age 1, as defined in Supplement 2 to Attachment 3.1-A in accordance with § 1915(g)(1) of the Act.

Provided, with limitations. See Supplement 2 for detail.

§ 20. Extended services to pregnant women.

20a. Pregnancy-related and postpartum services for 60 days after the pregnancy ends.

The same limitations on all covered services apply to this group as to all other recipient groups.

20b. Services for any other medical conditions that may complicate pregnancy.

The same limitations on all covered services apply to this group as to all other recipient groups.

§ 21. Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary of Health and Human Services.

21a. Transportation.

Transportation services are provided to Virginia Medicaid recipients to ensure that they have necessary access to and from providers of all medical services. Both emergency and nonemergency services are covered. The single state agency may enter into contracts with friends of recipients, nonprofit private agencies, and public carriers to provide transportation to Medicaid recipients.

21b. Services of Christian Science nurses.

Not provided.

21c. Care and services provided in Christian Science sanatoria.

Provided, no limitations.

21d. Skilled nursing facility services for patients under 21 years of age.

Provided, no limitations.

21e. Emergency hospital services.

Provided, no limitations.

21f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a

registered nurse.

Not provided.

§ 22. Emergency Services for Aliens.

A. No payment shall be made for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law unless such services are necessary for the treatment of an emergency medical condition of the alien.

B. Emergency services are defined as:

Emergency treatment of accidental injury or medical condition (including emergency labor and delivery) manifested by acute symptoms of sufficient severity (including severe pain) such that the absence to result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part.

C. Medicaid eligibility and reimbursement is conditional upon review of necessary documentation supporting the need for emergency services. Services and inpatient lengths of stay cannot exceed the limits established for other Medicaid recipients.

D. Claims for conditions which do not meet emergency criteria for treatment in an emergency room or for acute care hospital admissions for intensity of service or severity of illness will be denied reimbursement by the Department of Medical Assistance Services.

VR 460-02-3.1500. Standards for the Coverage of Organ Transplant Services.

The following criteria will be used to evaluate specific organ transplant requests.

PART I. KIDNEY TRANSPLANTATION.

§ 1.1. Patient selection criteria for provision of kidney transplantation (KT).

A. Transplantation of the kidney is a surgical treatment whereby a diseased kidney is replaced by a healthy organ. Preauthorization is required. The following patient selection criteria shall apply for the consideration of all approvals for coverage and reimbursement for kidney transplantation.

1. Current medical therapy has failed and patient has failed to respond to appropriate conservative management;

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2. The patient does not have other systemic disease including but not limited to the following:

- a. Reversible renal conditions;
- b. Major extra-renal complications (malignancy, systemic disease, cerebral cardio-arterial disease);
- c. Active infection;
- d. Severe malnutrition; or
- e. Pancytopenia.

3. The patient is not in both an irreversible terminal state and on a life support system;

4. Adequate supervision will be provided to assure there will be strict adherence to the medical regimen which is required;

5. The KT is likely to prolong life and restore a range of physical and social ~~function~~ *functions* suited to activities of daily living;

6. A facility with appropriate expertise has evaluated the patient, and has indicated willingness to undertake the procedure;

7. The patient does not have multiple uncorrectable severe major system congenital anomalies;

8. Failure to meet ~~(1)~~ *subdivisions 1* through ~~(7)~~ *above 7* shall result in denial of preauthorization and coverage for the requested kidney transplant procedures.

§ 1.2. Facility selection criteria for kidney transplantation (KT).

A. For medical facility to qualify as an approved Virginia Medicaid provider for performing kidney transplants, the following conditions must be met:

1. The facility has available expertise in immunology, infectious disease, pathology, pharmacology, and anesthesiology;
2. The KT program staff has extensive experience and expertise in the medical and surgical treatment of renal disease;
3. Transplant surgeons on the staff have been trained in the KT technique at an institution with a well established KT program;
4. The transplantation program has adequate services to provide specialized psychosocial and social support for patients and families;
5. Adequate blood bank support services are present

and available;

6. Satisfactory arrangements exist for donor procurement services;

7. The institution is committed to a program of at least 25 KTs a year;

8. The center has a consistent, equitable, and practical protocol for selection of patients (at a minimum, the DMAS Patient Selection Criteria must be met and adhered to);

9. The center has the capacity and commitment to conduct a systematic evaluation of outcome and cost;

10. In addition to hospital administration and medical staff endorsement, hospital staff support also exists for such a program;

11. The hospital has an active, ongoing renal dialysis service;

12. The hospital has access to staff with extensive skills in tissue typing, immunological and immunosuppressive techniques;

13. Initial approval as KT center requires performance of 25 KTs within the most recent 12 months, with a one year survival rate of at least 90%. Centers that fail to meet this requirement during the first year will be given a one-year conditional approval. Failure to meet the volume requirement following the conditional approval will result in loss of approval.

PART II. CORNEAL TRANSPLANTATION.

§ 2.1. Patient selection criteria for provision of corneal transplantation (CT).

A. Transplantation of the cornea is a surgical treatment whereby a diseased cornea is replaced by a healthy organ. While preauthorization is not required, the following patient selection criteria shall apply for the consideration of all approvals for reimbursement for cornea transplantation.

1. Current medical therapy has failed and will not prevent progressive disability;
2. The patient is suffering from one of the following conditions:
 - a. Post-cataract surgical decompensation,
 - b. Corneal dystrophy,
 - c. Post-traumatic scarring,
 - d. Keratoconus, or

e. Aphakia Bullous Keratopathy;

3. Adequate supervision will be provided to assure there will be strict adherence by the patient to the long term medical regimen which is required;

4. The CT is likely to restore a range of physical and social function suited to activities of daily living;

5. The patient is not in both an irreversible terminal state and on a life support system;

6. The patient does not have untreatable cancer, bacterial, fungal, or viral infection;

7. The patient does not have the following eye conditions:

a. Trichiasis,

b. Abnormal lid brush ~~and/or~~ or function or both ,

c. Tear film deficiency,

d. Raised transocular pressure,

e. Intensive inflammation, and

f. Extensive neo-vascularization.

§ 2.2. Facility selection criteria for cornea transplantation (CT).

A. For medical facility to qualify as an approved Medicaid provider for performing cornea transplants, the following conditions must be met:

1. The facility has available expertise in immunology, infectious disease, pathology, pharmacology, and anesthesiology;

2. The CT program staff has extensive experience and expertise in the medical and surgical treatment of eye disease;

3. Transplant surgeons on the staff have been trained in the CT technique at an institution with a well established CT program;

4. The transplantation program has adequate services to provide social support for patients and families;

5. Satisfactory arrangements exist for donor procurement services;

6. The institution is committed to a program of eye surgery;

7. The center has a consistent, equitable, and practical protocol for selection of patients (at a minimum, the DMAS Patient Selection Criteria must be met and

adhered to);

8. The center has the capacity and commitment to conduct a systematic evaluation of outcome and cost;

9. In addition to hospital administration and medical staff endorsement, hospital staff support also exists for such a program;

10. Initial approval as CT center requires performance of corneal transplant surgery, with a one year graft survival rate of at least 75%. Centers that fail to meet this requirement during the first year will be given a one-year conditional approval. Failure to meet this requirement following the conditional approval will result in loss of approval.

PART III. LIVER, HEART, ALLOGENEIC AND AUTOLOGOUS BONE MARROW TRANSPLANTATION AND ANY OTHER MEDICALLY NECESSARY TRANSPLANTATION PROCEDURES NOT DETERMINED EXPERIMENTAL OR INVESTIGATIONAL.

§ 3.1. Patient selection criteria for provision of liver, heart, allogeneic and autologous bone marrow transplantation and any other medically necessary transplantation procedures that are determined to not be experimental or investigational.

A. The following general conditions shall apply to these services:

1. Coverage shall not be provided for procedures that are provided on an investigational or experimental basis.

2. There must be no effective alternative medical or surgical therapies available with outcomes that are at least comparable.

3. The transplant procedure and application of the procedure in treatment of the specific condition for which it is proposed have been clearly demonstrated to be medically effective and not experimental or investigational.

4. Prior authorization by the Department of Medical Assistance Services (DMAS) is required. The prior authorization request must contain the information and documentation as required by DMAS.

B. The following patient selection criteria shall apply for the consideration of authorization and coverage and reimbursement:

1. The patient must be under 21 years of age at time of surgery.

2. The patient selection criteria of the transplant

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center where the surgery is to be performed shall be used in determining whether the patient is appropriate for selection for the procedure. Transplant procedures will be preauthorized only if the selection of the patient adheres to the transplant center's patient selection criteria, based upon review by DMAS of information submitted by the transplant team or center.

The recipient's medical condition shall be reviewed by the transplant team or program according to the transplant facility's patient selection criteria for that procedure and the recipient shall be determined by the team to be an appropriate transplant candidate. Patient selection criteria used by the transplant center shall include, but not necessarily be limited to, the following:

1. Current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management;
2. The patient is not in an irreversible terminal state; and
3. The transplant is likely to prolong life and restore a range of physical and social function suited to activities of daily living.

§ 3.2. Facility selection criteria for liver, heart, allogeneic and autologous bone marrow transplantation and any other medically necessary transplantation procedures that are determined to not be experimental or investigational.

A. The following general conditions shall apply:

1. Procedures may be performed out of state only when the authorized transplant cannot be performed in the Commonwealth because the service is not available or, due to capacity limitations, the transplant can not be performed in the necessary time period.
2. Criteria applicable to transplantation services and centers in the Commonwealth also apply to out-of-state transplant services and facilities.

B. To qualify for coverage, the facility must meet, but not necessarily be limited to, the following criteria:

1. The transplant program staff has demonstrated expertise and experience in the medical and surgical treatment of the specific transplant procedure;
2. The transplant surgeons have been trained in the specific transplant technique at an institution with a well established transplant program for the specific procedure;
3. The facility has expertise in immunology, infectious disease, pathology, pharmacology, and anesthesiology;

4. The facility has staff or access to staff with expertise in tissue typing, immunological and immunosuppressive techniques;

5. Adequate blood bank support services are available;

6. Adequate arrangements exist for donor procurement services;

7. Current full membership in the United Network for Organ Sharing, for the facilities where solid organ transplants are performed;

8. Membership in a recognized bone marrow accrediting or registry program for bone marrow transplantation programs;

9. The transplant facility or center can demonstrate satisfactory transplantation outcomes for the procedure being considered;

10. Transplant volume at the facility is consistent with maintaining quality services;

11. The transplant center will provide adequate psychosocial and social support services for the transplant recipient and family.

VA.R. Doc No. R94-951; Filed May 5, 1994, 11:23 a.m.

* * * * *

Title of Regulation: State Plan for Medical Assistance Relating to Home Health Reimbursement.
VR 460-03-4.1923. Establishment of Rate Per Visit.

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia.

Effective Date: July 1, 1994.

Summary:

The regulations provide for the fee-for-service reimbursement of home health agencies.

The section of the State Plan for Medical Assistance affected by this action is Supplement 3 to Attachment 4.19 B, Methods and Standards for Establishing Payment Rates – Other Types of Care, Establishment of Rate Per Visit.

The 1993 General Assembly (GA), in the Appropriations Act (Item 313.P), directed the Board of Medical Assistance Services to adopt revised regulations governing home health agency reimbursement methodologies, effective July 1, 1993,

that would (i) eliminate the distinction between urban and rural peer groups; (ii) utilize the weighted median cost per service from 1989 for freestanding agencies as a basis for establishing rates; and (iii) reimburse hospital-based home health agencies at the rate set for freestanding home health agencies. The GA also required that the adopted regulations comply with federal regulations regarding access to care. In addition, the Joint Legislative Audit and Review Commission (JLARC) recommended that a revision be made to the existing statistical methodology.

Before adoption of the emergency regulations, the agency's policy, effective July 1, 1991, changed the reimbursement methodology for home health services from cost reimbursed to fee based. It reimbursed home health agencies (HHAs) at a flat rate per visit for each type of service rendered and for each level of service for each of three peer groups (urban, rural and Northern Virginia). It further divided the three peer groups into freestanding and hospital-based HHAs and established the Department of Health's agencies as a separate peer group.

By virtue of the 1993 GA mandate, the peer groups no longer distinguished between freestanding and hospital-based HHAs and there no longer were urban and rural peer groups. The basis for establishing rates became the weighted median cost per service from the 1989 cost-settled Medicaid cost reports filed by freestanding HHAs. Based on certain JLARC recommendations, the agency modified its statistical approach by eliminating the adjustment to remove outliers before determining the peer group medians. The General Assembly action did not impact the separate peer group established for the Department of Health agencies.

After the close of the comment period on the proposed regulations, DMAS determined that clarifying language was needed to indicate clearly that Department of Health home health agencies' rates will continue to be determined by using data from its own cost report. Without the clarifying sentence at § 3 B, it might be interpreted that these agencies, which occupy their own unique peer group, were to use data from proprietary freestanding agencies' cost reports.

Summary of Public Comment and Agency Response: No public comment was received by the promulgating agency.

Agency Contact: Copies of the regulation may be obtained from Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219, telephone (804) 371-8850. There may be a charge for copies.

VR 460-03-4.1923. Establishment of Rate Per Visit.

§ 1. Effective for dates of services on and after July 1,

1991, the Department of Medical Assistance Services (DMAS) shall reimburse home health agencies (HHAs) at a flat rate per visit for each type of service rendered by HHAs (i.e., nursing, physical therapy, occupational therapy, speech-language pathology services, and home health aide services.) In addition, supplies left in the home and extraordinary transportation costs will be paid at specific rates.

§ 2. Effective for dates of services on and after July 1, 1993, DMAS shall establish a flat rate for each level of service for HHAs located in three by peer groups group. These peer groups shall be determined by the geographic location of the HHA's operating office and shall be classified as: URBAN, RURAL, or NORTHERN VIRGINIA. There shall be three peer groups: (i) the Department of Health's HHAs, (ii) non-Department of Health HHAs whose operating office is located in the Virginia portion of the Washington DC-MD-VA metropolitan statistical area, and (iii) non-Department of Health HHAs whose operating office is located in the rest of Virginia. The use of the Health Care Financing Administration (HCFA) designation of urban metropolitan statistical areas (MSAs) shall be incorporated in determining the appropriate peer group for these classifications.

§ 3. A separate grouping shall be established within each of the three peer groups to distinguish between freestanding and hospital-based HHAs. This shall account for the higher costs of hospital-based agencies resulting from Medicare cost allocation requirements. The Department of Health's agencies shall be established as being placed in another a separate peer group due to their unique cost characteristics (only one consolidated cost report is filed for all Department of Health agencies).

§ 3. Rates shall be calculated as follows:

1. A. Each home health agency shall be placed in its appropriate peer group.

2. B. Home health agencies' Department of Health HHAs' Medicaid cost per visit (exclusive of medical supplies costs) shall be obtained from its 1989 cost-settled Medicaid cost report. Non-Department of Health HHAs' Medicaid cost per visit (exclusive of medical supplies costs) shall be obtained from the 1989 cost-settled Medicaid Cost Reports filed by freestanding HHAs. Costs shall be inflated to a common point in time (June 30, 1991) by using the percent percentage of change in the moving average factor of the Data Resources, Inc. (DRI), National Forecast Tables for the Home Health Agency Market Basket.

3. C. To determine the flat rate per visit effective July 1, 1991-1993, the following methodology shall be utilized [: :]

a. Each HHA's per visit rate shall be normalized for those peer groups that have different wage indexes as determined by Medicare for the MSAs in

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Virginia:

b. The normalized HHA peer group rates and visits shall be adjusted to remove any HHA per visit rates that are outside of plus or minus one standard deviation from the peer group mean to eliminate any data that might distort the median rate per visit determination.

e. 1. The peer group HHA's per visit rates shall be ranked and weighted by the number of Medicaid visits per discipline to determine a median rate per visit for each peer group at July 1, 1991.

d. The HHA's rate effective July 1, 1991, shall be the lower of the peer group median or the Medicare upper limit per visit for each discipline.

2. The HHA's peer group median rate per visit for each peer group at July 1, 1991, shall be the interim peer group rate for calculating the update through January 1, 1992. The interim peer group rate shall be updated by 100% of historical inflation from July 1, 1991, through December 31, 1992, and shall become the final interim peer group rate which shall be updated by 50% of the forecasted inflation to the end of December 31, 1993, to establish the final peer group rates. The lower of the final peer group rates or the Medicare upper limit at January 1, 1993, will be effective for payments from July 1, 1993, through December 1993.

e. 3. Separate rates shall be provided for the initial assessment, follow-up, and comprehensive visits for skilled nursing and for the initial assessment and follow-up visits for physical therapy, occupational therapy, and speech therapy. The comprehensive rate shall be 200% of the follow-up rate, and the initial assessment rates shall be \$15 higher than the follow-up rates. The lower of the peer group median or Medicare upper limits shall be adjusted as appropriate to assure budget neutrality when the higher rates for the comprehensive and initial assessment visits are calculated.

4. D. The fee schedule shall be adjusted annually on or about January 1, based on the percent percentage of change in the moving average of Data Resources, Inc., National Forecast Tables for the Home Health Agency Market Basket determined in the third quarter of the previous calendar year. The method to calculate the annual update shall be:

a. The HHA's peer group rate effective July 1, 1991, shall become the final peer group rate for the first partial year ending December 31, 1991, and shall be the interim peer group rate for calculating the update January 1, 1992. For all HHA peer groups the interim peer group rate shall be updated for 100% of historical inflation from July 1, 1991, through December 31, 1991, and shall become the

final interim peer group rate which shall be updated by 50% of the forecasted inflation to the end of December 31, 1992, to establish the final peer group rate. The lower of the final peer group rates or the Medicare upper limit at January 1, 1992, will be effective for payments from January 1, 1992, through December 31, 1992.

There will be a one time adjustment made for those HHA final peer group rates that were established at July 1, 1991, based on the Medicare upper limits. The peer group median and the Medicare upper limit at July 1, 1991, shall be updated by 100% of historical inflation from July 1, 1991, through December 31, 1991. The final interim peer group rate shall be the lower of the two which shall be updated by 50% of the forecasted inflation to the end of December 31, 1992, to establish the final peer group. For these peer groups the lower of the final peer group rate or the Medicare upper limit at January 1, 1992, will be effective from July 1, 1992, through December 31, 1992.

b. 1. All subsequent year peer group rates shall be calculated utilizing this same method with the previous final interim peer group rate established on January 1 [,] becoming the interim peer group rate at December 31 [,] each year. The interim peer group rate shall be updated for 100% of historical inflation for the previous twelve months, January 1 through December 31, and shall become the final interim peer group rate which shall be updated by 50% of the forecasted inflation for the subsequent 12 months, January 1 through December 31.

e. 2. The annual update shall be compared to the Medicare upper limit per visit in effect on each January 1, and the HHA's shall receive the lower of the annual update or the Medicare upper limit per visit as the final peer group rate.

VA.R. Doc. No. R94-977; Filed May 11, 1994, 11:45 a.m.

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Health Care Financing Administration
OMB No. 0938-0357

MEDICAL UPDATE AND PATIENT INFORMATION

1. Patient's HI Claim No. 2. SOC Date 3. Certification Period 4. Medical Record No. 5. Provider No.

6. Patient's Name 7. Provider's Name

8. Medicare Covered: ☐ Y ☐ N 9. Date Physician Last Saw Patient: 10. Date Last Contacted Physician: 11. Is the Patient Receiving Care in an 1861 (JH) Skilled Nursing Facility or Equivalent? ☐ Y ☐ N Do Not Know ☐ Certification ☐ Recertification ☐ Modified ☐ 12. 13. Specific Services and Treatments

14. Date of Last Inpatient Stay Admission 15. Type of Facility: Discharge

16. Updated Information: New Orders/Treatments/Clinical Facts/Summary from Each Discipline

17. Functional Limitations (Expand From 485 and Level of ADL) Reason Homebound/Prior Functional Status

18. Supplementary Plan of Treatment on File from Physician Other than Referring Physician: (If Yes, Please Specify Goals/Rehab. Potential/Discharge Plan) ☐ Y ☐ N

19. Unusual Home/Social Environment

20. Indicate Any Time When the Home Health Agency Made a Visit and Patient was Not Home and Reason Why if Ascertainable 21. Specify Any Known Medical and/or Non-Medical Reasons the Patient Regularly Leaves Home and Frequency of Occurrence

22. Nurse or Therapist Completing or Reviewing Form Date (Mo., Day, Yr.)

Form HCFA-486 (03) (4-87) DEPUTY NIP

Health Care Financing Administration
OMB No. 0938-0357

HOME HEALTH CERTIFICATION AND PLAN OF TREATMENT

1. Patient's HI Claim No. 2. SOC Date 3. Certification Period 4. Medical Record No. 5. Provider No.

6. Patient's Name and Address 7. Provider's Name and Address

8. Date of Birth: 9. Sex: M ☐ F ☐ 10. Medications: Dose/Frequency/Route (New/Changed)

11. ICD-9-CM Principal Diagnosis Date 12. ICD-9-CM Surgical Procedure Date 13. ICD-9-CM Other Patient Diagnoses Date

14. OME and Supplies 15. Safety Measures:

16. Nutritional Req. 17. Allergies:

18.A. Activities Permitted

1. Ambulation	5. Proximal	9. Legally Blind	13. Conscious	17. Reason
2. Stairclimbing	6. Endurance	10. Driving (With/Without License)	14. Disoriented	18. At Home
3. Transferring	7. Ambulation	11. Other (Specify)	15. Disoriented	19. On Bed
4. Feeding	8. Speech		16. Disoriented	20. Other (Specify)

19. Mental Status: 1. Oriented 2. Confused 3. Delirious 4. Comatose 5. Unresponsive

20. Prognosis: 1. Poor 2. Guarded 3. Fair 4. Good 5. Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

22. Goals/Rehabilitation Potential/Discharge Plans

23. Verbal Start of Care and Nurse's Signature and Date Where Applicable

24. Physician's Name and Address

25. Date HHA Received Signed POT

26. Date HHA Received Signed POT

27. Attending Physician's Signature (Required on 485 Kept on File in Medical Records at HHA) Date Signed

Form HCFA-486 (04) (4-87) PHYSICIAN

Department of Health and Human Services Health Care Financing Administration		Form Approved CMS No. 0938-0357	
ADDENDUM TO:		<input type="checkbox"/> PLAN OF TREATMENT	<input type="checkbox"/> MEDICAL UPDATE
1. Patient's HI Claim No.	2. SOC Date	3. Certification Period From: To:	4. Medical Record No.
5. Provider No.		6. Patient's Name	
7. Provider Name		8. Item No.	
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">REGISTER OF REGULATIONS 93 DEC -7 PM 4: 24</p>			
9. Signature of Physician		10. Date	
11. Optional Name/Signature of Nurse/Therapist		12. Date	

Form HFA-107 (10-11-88)

DUPLICATE

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Title of Regulation: State Plan for Medical Assistance Relating to 95% Rule; Criminal Record Checks; Blood Borne Pathogens.

VR 460-03-4.1940:1. Nursing Home Payment System.

VR 460-03-4.1941. Uniform Expense Classification.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Effective Date: July 1, 1994.

Summary:

The purpose of this action is to promulgate permanent regulations, to supersede the existing emergency regulations, regarding nursing facility 95% occupancy rule and criminal record checks. This action also provides for permanent regulations for the reimbursement for nursing facilities' costs of complying with OSHA requirements for protecting employees against exposure to blood borne pathogens.

95% Occupancy Rule

Prior to the emergency regulation, DMAS set a new nursing facility's (NF's) interim plant rate for its first fiscal year based on estimated financial data and estimated days. This interim plant rate would remain in effect until approximately the ninth month of the NF's second fiscal year, at which time the NF's first fiscal year would be settled. When the NF's first fiscal year was settled, a new interim plant rate would be established for the second fiscal year based on actual plant costs and 95% of the available bed days. This generally produced an interim plant rate that was lower than the rate the NF was being paid and consequently resulted in a new provider receiving substantial overpayment during the first nine months of the second fiscal year. This amendment provides that the 95% occupancy rule will be applied on the first day of a new provider's second fiscal year. The effect of this amendment will be to eliminate any potential overpayments in the first nine months of the provider's second fiscal year.

Criminal Record Checks

The 1993 General Assembly, in Chapter 994 of the Acts of Assembly of 1993 (Item 313. T), directed DMAS to adopt revised regulations and forms governing nursing facilities that would reimburse providers for the costs of complying with the requirement to obtain criminal record background checks on nursing facility employees, as implemented by § 32.1-126.01 of the Code of Virginia.

Prior to the emergency regulation, nursing facilities were required, by § 32.1-126.01 of the Code of Virginia, to obtain, within 30 days of employment, an original criminal record clearance or an original

criminal history record from the Central Criminal Records Exchange for each new employee. The nursing facility was prohibited from hiring an individual who had been convicted of any of the crimes enumerated in § 32.1-126.01 of the Code of Virginia.

The 1993 General Assembly, in Chapter 994 of the Acts of Assembly of 1993 (Item 313. T) required that the provider be reimbursed for the cost of obtaining the criminal records check, made by the Central Criminal Records Exchange, by a pass-through methodology similar to that used to reimburse plant costs.

Blood Borne Pathogens

The Occupational Safety and Health Administration (OSHA) promulgated a standard, effective March 6, 1992, to eliminate or minimize occupational exposure to blood borne pathogens (final rule published in the December 6, 1991, Federal Register, adopting 29 CFR 1910.1030). The Virginia Safety and Health Codes Board of the Department of Labor and Industry adopted these regulations as VR 415-02-83, effective June 1, 1992 (published in The Virginia Register of Regulations, pp. 2145-2158, March 23, 1992).

The Joint Legislative Audit and Review Commission, in its December 1992 study of Medicaid-financed long-term care in Virginia, recommended that DMAS develop a methodology to determine the costs of Virginia's requirement that nursing home employees be protected from blood borne pathogens. The General Assembly (in Item 312.1 of the 1993 Appropriations Act) directed DMAS to study the cost of reimbursing nursing facilities for complying with these new requirements.

DMAS has completed its study and, with input from the nursing facility community, is revising the State Plan to permit reimbursement for these required costs. The General Assembly (in Item 396.E.4. of the 1994 Appropriations Act) directed DMAS to increase nursing facility peer group ceilings by the per day cost of compliance with the OSHA requirements, effective July 1, 1994. The indirect peer group ceilings applicable to all facilities will be increased by not more than \$.09 per day for the Hepatitis B immunizations and by \$.07 per day for other OSHA compliance costs. This rate adjustment will be increased for inflation for SFY 1996 and following.

Summary of Public Comment and Agency Response: No public comment was received by the promulgating agency.

Agency Contact: Copies of the regulation may be obtained from Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219, telephone (804) 371-8850. There may be a charge for copies.

VR 460-03-4.1940:1. Nursing Home Payment System Patient Intensity Rating System.

PART I. INTRODUCTION.

§ 1.1. Effective October 1, 1990, the payment methodology for Nursing Facility (NF) reimbursement by the Virginia Department of Medical Assistance Services (DMAS) is set forth in the following document. The formula provides for incentive payments to efficiently operated NFs and contains payment limitations for those NFs operating less efficiently. A cost efficiency incentive encourages cost containment by allowing the provider to retain a percentage of the difference between the prospectively determined operating cost rate and the ceiling.

§ 1.2. Three separate cost components are used: plant cost, operating cost and nurse aide training and competency evaluation program and competency evaluation program (NATCEPs) costs. The rates, which are determined on a facility-by-facility basis, shall be based on annual cost reports filed by each provider.

§ 1.3. In determining the ceiling limitations, there shall be direct patient care medians established for NFs in the Virginia portion of the Washington DC-MD-VA Metropolitan Statistical Area (MSA), the Richmond-Petersburg Metropolitan Statistical Area (MSA), and in the rest of the state. There shall be indirect patient care medians established for NFs in the Virginia portion of the Washington DC-MD-VA MSA, and in the rest of the state. The Washington DC-MD-VA MSA and the Richmond-Petersburg MSA shall include those cities and counties as listed and changed from time to time by the Health Care Financing Administration (HCFA). A NF located in a jurisdiction which HCFA adds to or removes from the Washington DC-MD-VA MSA or the Richmond-Petersburg MSA shall be placed in its new peer group, for purposes of reimbursement, at the beginning of its next fiscal year following the effective date of HCFA's final rule.

§ 1.4. Institutions for mental diseases providing nursing services for individuals age 65 and older shall be exempt from the prospective payment system as defined in §§ 2.6, 2.7, 2.8, 2.19, and 2.25, as are mental retardation facilities. All other sections of this payment system relating to reimbursable cost limitations shall apply. These facilities shall continue to be reimbursed retrospectively on the basis of reasonable costs in accordance with Medicare and Medicaid principles of reimbursement. Reimbursement to Intermediate Care Facilities for the Mentally Retarded (ICF/MR) shall be limited to the highest rate paid to a state ICF/MR institution, approved each July 1 by DMAS.

§ 1.5. Except as specifically modified herein, Medicare principles of reimbursement, as amended from time to time, shall be used to establish the allowable costs in the rate calculations. Allowable costs must be classified in accordance with the DMAS uniform chart of accounts (see

VR 460-03-4.1941, Uniform Expense Classification) and must be identifiable and verified by contemporaneous documentation.

All matters of reimbursement which are part of the DMAS reimbursement system shall supercede Medicare principles of reimbursement. Wherever the DMAS reimbursement system conflicts with Medicare principles of reimbursement, the DMAS reimbursement system shall take precedence. Appendices are a part of the DMAS reimbursement system.

PART II. RATE DETERMINATION PROCEDURES.

Article 1. Plant Cost Component.

§ 2.1. Plant cost.

A. Plant cost shall include actual allowable depreciation, interest, rent or lease payments for buildings and equipment as well as property insurance, property taxes and debt financing costs allowable under Medicare principles of reimbursement or as defined herein.

B. To calculate the reimbursement rate, plant cost shall be converted to a per diem amount by dividing it by the greater of actual patient days or the number of patient days computed as 95% of the daily licensed bed complement during the applicable cost reporting period.

C. For NFs of 30 beds or less, to calculate the reimbursement rate, the number of patient days will be computed as not less than 85% of the daily licensed bed complement.

D. Costs related to equipment and portions of a building/facility not available for patient care related activities are nonreimbursable plant costs.

§ 2.2. New nursing facilities and bed additions.

A. 1. Providers shall be required to obtain three competitive bids when (i) constructing a new physical plant or renovating a section of the plant when changing the licensed bed capacity, and (ii) purchasing fixed equipment or major movable equipment related to such projects.

2. All bids must be obtained in an open competitive market manner, and subject to disclosure to DMAS prior to initial rate setting. (Related parties see § 2.10.)

B. Reimbursable costs for building and fixed equipment shall be based upon the 3/4 (25% of the surveyed projects with costs above the median, 75% with costs below the median) square foot costs for NFs published annually in the R.S. Means Building Construction Cost Data as adjusted by the appropriate R.S. Means Square Foot Costs "Location

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Factor" for Virginia for the locality in which the NF is located. Where the specific location is not listed in the R.S. Means Square Foot Costs "Location Factor" for Virginia, the facility's zip code shall be used to determine the appropriate locality factor from the U.S. Postal Services National Five Digit Zip Code for Virginia and the R.S. Means Square Foot Costs "Location Factors." The provider shall have the option of selecting the construction cost limit which is effective on the date the Certificate of Public Need (COPN) is issued or the date the NF is licensed. Total cost shall be calculated by multiplying the above 3/4 square foot cost by 385 square feet (the average per bed square footage). Total costs for building additions shall be calculated by multiplying the square footage of the project by the applicable components of the construction cost in the R.S. Means Square Foot Costs, not to exceed the total per bed cost for a new NF. Reasonable limits for renovations shall be determined by the appropriate costs in the R.S. Means Repair and Remodeling Cost Data, not to exceed the total R.S. Means Building Construction Cost Data 3/4 square foot costs for nursing homes.

C. New NFs and bed additions to existing NFs must have prior approval under the state's Certificate of Public Need Law and Licensure regulations in order to receive Medicaid reimbursement.

D. However in no case shall allowable reimbursed costs exceed 110% of the amounts approved in the original COPN, or 100% of the amounts approved in the original COPN as modified by any "significant change" COPN, where a provider has satisfied the requirements of the State Department of Health with respect to obtaining prior written approval for a "significant change" to a COPN which has previously been issued.

§ 2.3. Major capital expenditures.

A. Major capital expenditures include, but are not limited to, major renovations (without bed increase), additions, modernization, other renovations, upgrading to new standards, and equipment purchases. Major capital expenditures shall be any capital expenditures costing \$100,000 or more each, in aggregate for like items, or in aggregate for a particular project. These include purchases of similar type equipment or like items within a one calendar year period (not necessarily the provider's reporting period).

B. Providers (including related organizations as defined in § 2.10) shall be required to obtain three competitive bids and if applicable, a Certificate of Public Need before initiating any major capital expenditures. All bids must be obtained in an open competitive manner, and subject to disclosure to the DMAS prior to initial rate setting. (Related parties see § 2.10.)

C. Useful life shall be determined by the American Hospital Association's Estimated Useful Lives of Depreciable Hospital Assets (AHA). If the item is not

included in the AHA guidelines, reasonableness shall be applied to determine useful life.

D. Major capital additions, modernization, renovations, and costs associated with upgrading the NF to new standards shall be subject to cost limitations based upon the applicable components of the construction cost limits determined in accordance with § 2.2 B.

§ 2.4. Financing.

A. The DMAS shall continue its policy to disallow cost increases due to the refinancing of a mortgage debt, except when required by the mortgage holder to finance expansions or renovations. Refinancing shall also be permitted in cases where refinancing would produce a lower interest rate and result in a cost savings. The total net aggregate allowable costs incurred for all cost reporting periods related to the refinancing cannot exceed the total net aggregate costs that would have been allowable had the refinancing not occurred.

1. Refinancing incentive. Effective July 1, 1991, for mortgages refinanced on or after that date, the DMAS will pay a refinancing incentive to encourage nursing facilities to refinance fixed-rate, fixed-term mortgage debt when such arrangements would benefit both the Commonwealth and the providers. The refinancing incentive payments will be made for the 10-year period following an allowable refinancing action, or through the end of the refinancing period should the loan be less than 10 years, subject to a savings being realized by application of the refinancing calculation for each of these years. The refinancing incentive payment shall be computed on the net savings from such refinancing applicable to each provider cost reporting period. Interest expense and amortization of loan costs on mortgage debt applicable to the cost report period for mortgage debt which is refinanced shall be compared to the interest expense and amortization of loan costs on the new mortgage debt for the cost reporting period.

2. Calculation of refinancing incentive. The incentive shall be computed by calculating two index numbers, the old debt financing index and the new debt financing index. The old debt financing index shall be computed by multiplying the term (months) which would have been remaining on the old debt at the end of the provider's cost report period by the interest rate for the old debt. The new debt index shall be computed by multiplying the remaining term (months) of the new debt at the end of the cost reporting period by the new interest rate. The new debt index shall be divided by the old debt index to achieve a savings ratio for the period. The savings ratio shall be subtracted from a factor of 1 to determine the refinancing incentive factor.

3. Calculation of net savings. The gross savings for the period shall be computed by subtracting the allowable

new debt interest for the period from the allowable old debt interest for the period. The net savings for the period shall be computed by subtracting allowable new loan costs for the period from allowable gross savings applicable to the period. Any remaining unamortized old loan costs may be recovered in full to the extent of net savings produced for the period.

4. Calculation of incentive amount. The net savings for the period, after deduction of any unamortized old loan and debt cancellation costs, shall be multiplied by the refinancing incentive factor to determine the refinancing incentive amount. The result shall be the incentive payment for the cost reporting period, which shall be included in the cost report settlement, subject to per diem computations under § 2.1 B, 2.1 C, and 2.14 A.

5. Where a savings is produced by a provider refinancing his old mortgage for a longer time period, the DMAS shall calculate the refinancing incentive and payment in accordance with §§ 2.4 A 1 through 2.4 A 4 for the incentive period. Should the calculation produce both positive and negative incentives, the provider's total incentive payments shall not exceed any net positive amount for the entire incentive period. Where a savings is produced by refinancing with either a principal balloon payment at the end of the refinancing period, or a variable interest rate, no incentive payment will be made, since the true savings to the Commonwealth cannot be accurately computed.

6. All refinancings must be supported by adequate and verifiable documentation and allowable under DMAS regulations to receive the refinancing savings incentive.

B. Interest rate upper limit.

Financing for all NFs and expansions which require a COPN and all renovations and purchases shall be subject to the following limitations:

1. Interest expenses for debt financing which is exempt from federal income taxes shall be limited to:

The average weekly rates for Baa municipal rated bonds as published in Cragie Incorporated Municipal Finance Newsletter as published weekly (Representative reoffering from general obligation bonds), plus one percentage point (100 basis points), during the week in which commitment for construction financing or closing for permanent financing takes place.

2. a. Effective on and after July 1, 1990, the interest rate upper limit for debt financing by NFs that are subject to prospective reimbursement shall be the average of the rate for 10-year and 30-year U.S. Treasury Constant Maturities, as published in the weekly Federal Reserve Statistical Release (H.15), plus

two percentage points (200 basis points).

This limit (i) shall apply only to debt financing which is not exempt from federal income tax, and (ii) shall not be available to NFs which are eligible for such tax exempt financing unless and until a NF has demonstrated to the DMAS that the NF failed, in a good faith effort, to obtain any available debt financing which is exempt from federal income tax. For construction financing, the limit shall be determined as of the date on which commitment takes place. For permanent financing, the limit shall be determined as of the date of closing. The limit shall apply to allowable interest expenses during the term of the financing.

b. The new interest rate upper limit shall also apply, effective July 1, 1990, to construction financing committed to or permanent financing closed after December 31, 1986, but before July 1, 1990, which is not exempt from federal income tax. The limit shall be determined as of July 1, 1990, and shall apply to allowable interest expenses for the term of the financing remaining on or after July 1, 1990.

3. Variable interest rate upper limit.

a. The limitation set forth in §§ 2.4 B 1 and 2.4 B 2 shall be applied to debt financing which bears a variable interest rate as follows. The interest rate upper limit shall be determined on the date on which commitment for construction financing or closing for permanent financing takes place, and shall apply to allowable interest expenses during the term of such financing as if a fixed interest rate for the financing period had been obtained. A "fixed rate loan amortization schedule" shall be created for the loan period, using the interest rate cap in effect on the date of commitment for construction financing or date of closing for permanent financing.

b. If the interest rate for any cost reporting period is below the limit determined in subdivision 3 a above, no adjustment will be made to the providers interest expense for that period, and a "carryover credit" to the extent of the amount allowable under the "fixed rate loan amortization schedule" will be created, but not paid. If the interest rate in a future cost reporting period is above the limit determined in subdivision 3 a above, the provider will be paid this "carryover credit" from prior period(s), not to exceed the cumulative carryover credit or his actual cost, whichever is less.

c. The provider shall be responsible for preparing a verifiable and auditable schedule to support cumulative computations of interest claimed under the "carryover credit," and shall submit such a schedule with each cost report.

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4. The limitation set forth in § 2.4 B 1, 2, and 3 shall be applicable to financing for land, buildings, fixed equipment, major movable equipment, working capital for construction and permanent financing.

5. Where bond issues are used as a source of financing, the date of sale shall be considered as the date of closing.

6. The aggregate of the following costs shall be limited to 5.0% of the total allowable project costs:

- a. Examination Fees
- b. Guarantee Fees
- c. Financing Expenses (service fees, placement fees, feasibility studies, etc.)
- d. Underwriters Discounts
- e. Loan Points

7. The aggregate of the following financing costs shall be limited to 2.0% of the total allowable project costs:

- a. Legal Fees
- b. Cost Certification Fees
- c. Title and Recording Costs
- d. Printing and Engraving Costs
- e. Rating Agency Fees

C. DMAS shall allow costs associated with mortgage life insurance premiums in accordance with § 2130 of the HCFA-Pub. 15, Provider Reimbursement Manual (PRM-15).

D. Interest expense on a debt service reserve fund is an allowable expense if required by the terms of the financing agreement. However, interest income resulting from such fund shall be used by DMAS to offset interest expense.

§ 2.5. Purchases of nursing facilities (NF).

A. In the event of a sale of a NF, the purchaser must have a current license and certification to receive DMAS reimbursement as a provider.

B. The following reimbursement principles shall apply to the purchase of a NF:

- 1. The allowable cost of a bona fide sale of a facility (whether or not the parties to the sale were, are, or will be providers of Medicaid services) shall be the lowest of the sales price, the replacement cost value determined by independent appraisal, or the limitations of Part XVI - Revaluation of Assets.

Revaluation of assets shall be permitted only when a bona fide sale of assets occurs.

2. Notwithstanding the provisions of § 2.10, where there is a sale between related parties (whether or not they were, are or will be providers of Medicaid services), the buyer's allowable cost basis for the nursing facility shall be the seller's allowable depreciated historical cost (net book value), as determined for Medicaid reimbursement.

3. For purposes of Medicaid reimbursement, a "bona fide" sale shall mean a transfer of title and possession for consideration between parties which are not related. Parties shall be deemed to be "related" if they are related by reasons of common ownership or control. If the parties are members of an immediate family, the sale shall be presumed to be between related parties if the ownership or control by immediate family members, when aggregated together, meets the definitions of "common ownership" or "control." See § 2.10 C for definitions of "common ownership," "control," "immediate family," and "significant ownership or control."

4. The useful life of the fixed assets of the facility shall be determined by AHA guidelines.

5. The buyer's basis in the purchased assets shall be reduced by the value of the depreciation recapture due the state by the provider-seller, until arrangements for repayment have been agreed upon by DMAS.

6. In the event the NF is owned by the seller for less than five years, the reimbursable cost basis of the purchased NF to the buyer, shall be the seller's allowable historical cost as determined by DMAS.

C. An appraisal expert shall be defined as an individual or a firm that is experienced and specializes in multi-purpose appraisals of plant assets involving the establishing or reconstructing of the historical cost of such assets. Such an appraisal expert employs a specially trained and supervised staff with a complete range of appraisal and cost construction techniques; is experienced in appraisals of plant assets used by providers, and demonstrates a knowledge and understanding of the regulations involving applicable reimbursement principles, particularly those pertinent to depreciation; and is unrelated to either the buyer or seller.

D. At a minimum, appraisals must include a breakdown by cost category as follows:

- 1. Building; fixed equipment; movable equipment; land; land improvements.
- 2. The estimated useful life computed in accordance with AHA guidelines of the three categories, building, fixed equipment, and movable equipment must be

included in the appraisal. This information shall be utilized to compute depreciation schedules.

E. Depreciation recapture.

1. The provider-seller of the facility shall make a retrospective settlement with DMAS in instances where a gain was made on disposition. The department shall recapture the depreciation paid to the provider by Medicaid for the period of participation in the Program to the extent there is gain realized on the sale of the depreciable assets. A final cost report and refund of depreciation expense, where applicable, shall be due within 30 days from the transfer of title (as defined below).

2. No depreciation adjustment shall be made in the event of a loss or abandonment.

F. Reimbursable depreciation.

1. For the purpose of this section, "sale or transfer" shall mean any agreement between the transferor and the transferee by which the former, in consideration of the payment or promise of payment of a certain price in money, transfers to the latter the title and possession of the property.

2. Upon the sale or transfer of the real and tangible personal property comprising a licensed nursing facility certified to provide services to DMAS, the transferor or other person liable therein shall reimburse to the Commonwealth the amount of depreciation previously allowed as a reasonable cost of providing such services and subject to recapture under the provisions of the State Plan for Medical Assistance. The amount of reimbursable depreciation shall be paid to the Commonwealth within 30 days of the sale or transfer of the real property unless an alternative form of repayment, the term of which shall not exceed one year, is approved by the director.

3. Prior to the transfer, the transferor shall file a written request by certified or registered mail to the director for a letter of verification that he either does not owe the Commonwealth any amount for reimbursable depreciation or that he has repaid any amount owed the Commonwealth for reimbursable depreciation or that an alternative form of repayment has been approved by the director. The request for a letter of verification shall state:

a. That a sale or transfer is about to be made;

b. The location and general description of the property to be sold or transferred;

c. The names and addresses of the transferee and transferor and all such business names and addresses of the transferor for the last three years;

and

d. Whether or not there is a debt owing to the Commonwealth for the amount of depreciation charges previously allowed and reimbursed as a reasonable cost to the transferor under the Virginia Medical Assistance Program.

4. Within 90 days after receipt of the request, the director shall determine whether or not there is an amount due to the Commonwealth by the nursing facility by reason of depreciation charges previously allowed and reimbursed as a reasonable cost under DMAS and shall notify the transferor of such sum, if any.

5. The transferor shall provide a copy of this section and a copy of his request for a letter of verification to the prospective transferee via certified mail at least 30 days prior to the transfer. However, whether or not the transferor provides a copy of this section and his request for verification to the prospective transferee as required herein, the transferee shall be deemed to be notified of the requirements of this law.

6. After the transferor has made arrangements satisfactory to the director to repay the amount due or if there is no amount due, the director shall issue a letter of verification to the transferor in recordable form stating that the transferor has complied with the provisions of this section and setting forth the term of any alternative repayment agreement. The failure of the transferor to reimburse to the Commonwealth the amount of depreciation previously allowed as a reasonable cost of providing service to DMAS in a timely manner renders the transfer of the nursing facility ineffective as to the Commonwealth.

7. Upon a finding by the director that such sale or transfer is ineffective as to the Commonwealth, DMAS may collect any sum owing by any means available by law, including devising a schedule for reducing the Medicaid reimbursement to the transferee up to the amount owed the Commonwealth for reimbursable depreciation by the transferor or other person liable therein. Medicaid reimbursement to the transferee shall continue to be so reduced until repayment is made in full or the terms of the repayment are agreed to by the transferor or person liable therein.

8. In the event the transferor or other person liable therein defaults on any such repayment agreement the reductions of Medicaid reimbursement to the transferee may resume.

An action brought or initiated to reduce the transferee's Medicaid reimbursement or an action for attachment or levy shall not be brought or initiated more than six months after the date on which the sale or transfer has taken place unless the sale or transfer has been concealed or a letter of verification

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has not been obtained by the transferor or the transferor defaults on a repayment agreement approved by the director.

Article 2.

Operating Cost Component.

§ 2.6. Operating cost.

A. Operating cost shall be the total allowable inpatient cost less plant cost and NATCEPs costs. See Part VII for rate determination procedures for NATCEPs costs. To calculate the reimbursement rate, operating cost shall be converted to a per diem amount by dividing it by the greater of actual patient days, or the number of patient days computed as 95% of the daily licensed bed complement during the applicable cost reporting period.

B. For NFs of 30 beds or less, to calculate the reimbursement rate the number of patient days will continue to be computed as not less than 85% of the daily licensed bed complement.

§ 2.7. Nursing facility reimbursement formula.

A. Effective on and after October 1, 1990, all NFs subject to the prospective payment system shall be reimbursed under a revised formula entitled "The Patient Intensity Rating System (PIRS)." PIRS is a patient based methodology which links NF's per diem rates to the intensity of services required by a NF's patient mix. Three classes were developed which group patients together based on similar functional characteristics and service needs.

1. Any NF receiving Medicaid payments on or after October 1, 1990, shall satisfy all the requirements of § 1919(b) through (d) of the Social Security Act as they relate to provision of services, residents' rights and administration and other matters.

2. In accordance with § 1.3, direct patient care operating cost peer groups shall be established for the Virginia portion of the Washington DC-MD-VA MSA, the Richmond-Petersburg MSA and the rest of the state. Direct patient care operating costs shall be as defined in VR 460-03-1491. Indirect patient care operating cost peer groups shall be established for the Virginia portion of the Washington DC-MD-VA MSA and for the rest of the state. Indirect patient care operating costs shall include all other operating costs, not defined in VR 460-03-4.1941 as direct patient care operating costs and NATCEPs costs.

3. Each NF's Service Intensity Index (SII) shall be calculated for each semiannual period of a NF's fiscal year based upon data reported by that NF and entered into DMAS' Long Term Care Information System (LTCIS). Data will be reported on the multidimensional assessment form prescribed by DMAS (now DMAS-95) at the time of admission and then

twice a year for every Medicaid recipient in a NF. The NF's SII, derived from the assessment data, will be normalized by dividing it by the average for all NF's in the state.

See VR 460-03-4.1944 for the PIRS class structure, the relative resource cost assigned to each class, the method of computing each NF's facility score and the methodology of computing the NF's semiannual SIIs.

4. The normalized SII shall be used to calculate the initial direct patient care operating cost peer group medians. It shall also be used to calculate the direct patient care operating cost prospective ceilings and direct patient care operating cost prospective rates for each semiannual period of a NF's subsequent fiscal years.

a. The normalized SII, as determined during the quarter ended September 30, 1990, shall be used to calculate the initial direct patient care operating cost peer group medians.

b. A NF's direct patient care operating cost prospective ceiling shall be the product of the NF's peer group direct patient care ceiling and the NF's normalized SII for the previous semiannual period. A NF's direct patient care operating cost prospective ceiling will be calculated semiannually.

c. An SSI rate adjustment, if any, shall be applied to a NF's prospective direct patient care operating cost base rate for each semiannual period of a NF's fiscal year. The SII determined in the second semiannual period of the previous fiscal year shall be divided by the average of the previous fiscal year's SIIs to determine the SII rate adjustment, if any, to the first semiannual period of the subsequent fiscal year's prospective direct patient care operating cost base rate. The SII determined in the first semiannual period of the subsequent fiscal year shall be divided by the average of the previous fiscal year's SIIs to determine the SII rate adjustment, if any, to the second semiannual period of the subsequent fiscal year's prospective direct patient care operating cost base rate.

d. See VR 460-03-4.1944 for an illustration of how the SII is used to adjust direct patient care operating ceilings and the semiannual rate adjustments to the prospective direct patient care operating cost base rate.

5. An adjustment factor shall be applied to both the direct patient care and indirect patient care peer group medians to determine the appropriate initial peer group ceilings.

a. The DMAS shall calculate the estimated gross NF reimbursement required for the forecasted number of NF bed days during fiscal year 1991 under the

prospective payment system in effect through September 30, 1990, as modified to incorporate the estimated additional NF reimbursement mandated by the provisions of § 1902(a)(13)(A) of the Social Security Act as amended by § 4211(b)(1) of the Omnibus Budget Reconciliation Act of 1987.

b. The DMAS shall calculate the estimated gross NF reimbursement required for the forecasted number of NF bed days during FY 1991 under the PIRS prospective payment system.

c. The DMAS shall determine the differential between a and b above and shall adjust the peer group medians within the PIRS as appropriate to reduce the differential to zero.

d. The adjusted PIRS peer group medians shall become the initial peer group ceilings.

B. The allowance for inflation shall be based on the percentage of change in the moving average of the Skilled Nursing Facility Market basket of Routine Service Costs, as developed by Data Resources, Incorporated, adjusted for Virginia, determined in the quarter in which the NF's most recent fiscal year ended. NFs shall have their prospective operating cost ceilings and prospective operating cost rates established in accordance with the following methodology:

1. The initial peer group ceilings established under § 2.7 A shall be the final peer group ceilings for a NF's first full or partial fiscal year under PIRS and shall be considered as the initial "interim ceilings" for calculating the subsequent fiscal year's peer group ceilings. Peer group ceilings for subsequent fiscal years shall be calculated by adjusting the initial "interim" ceilings by a "percentage factor" which shall eliminate any allowances for inflation after September 30, 1990, calculated in both §§ 2.7 A 5 a and 2.7 A 5 c. The adjusted initial "interim" ceilings shall be considered as the final "interim ceiling." Peer group ceilings for subsequent fiscal years shall be calculated by adjusting the final "interim" ceiling, as determined above, by 100% of historical inflation from October 1, 1990, to the beginning of the NFs next fiscal year to obtain new "interim" ceilings, and 50% of the forecasted inflation to the end of the NFs next fiscal year.

2. A NF's average allowable operating cost rates, as determined from its most recent fiscal year's cost report, shall be adjusted by 50% of historical inflation and 50% of the forecasted inflation to calculate its prospective operating cost base rates.

C. The PIRS method shall still require comparison of the prospective operating cost rates to the prospective operating ceilings. The provider shall be reimbursed the lower of the prospective operating cost rates or prospective operating ceilings.

D. Nonoperating costs.

1. Allowable plant costs shall be reimbursed in accordance with Part II, Article 1. Plant costs shall not include the component of cost related to making or producing a supply or service.

2. NATCEPs cost shall be reimbursed in accordance with Part VII.

E. The prospective rate for each NF shall be based upon operating cost and plant cost components or charges, whichever is lower, plus NATCEPs costs. The disallowance of nonreimbursable operating costs in any current fiscal year shall be reflected in a subsequent year's prospective rate determination. Disallowances of nonreimbursable plant costs and NATCEPs costs shall be reflected in the year in which the nonreimbursable costs are included.

F. For those NFs whose operating cost rates are below the ceilings, an incentive plan shall be established whereby a NF shall be paid, on a sliding scale, up to 25% of the difference between its allowable operating cost rates and the peer group ceilings under the PIRS.

1. The table below presents four incentive examples under the PIRS:

Peer Group Ceilings	Allowable Cost Per Day		Difference % of Ceiling	Sliding Scale	Scale % Dif ference
\$30.00	\$27.00	\$3.00	10%	\$.30	10%
30.00	22.50	7.50	25%	1.88	25%
30.00	20.00	10.00	33%	2.50	25%
30.00	30.00	0		0	

2. Separate efficiency incentives shall be calculated for both the direct and indirect patient care operating ceilings and costs.

G. Quality of care requirement.

A cost efficiency incentive shall not be paid to a NF for the prorated period of time that it is not in conformance with substantive, nonwaived life, safety, or quality of care standards.

H. Sale of facility.

In the event of the sale of a NF, the prospective base operating cost rates for the new owner's first fiscal period shall be the seller's prospective base operating cost rates before the sale.

I. Public notice.

To comply with the requirements of § 1902(a)(28)(c) of the Social Security Act, DMAS shall make available to the public the data and methodology used in establishing Medicaid payment rates for nursing facilities. Copies may be obtained by request under the existing procedures of the Virginia Freedom of Information Act.

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§ 2.8. Phase-in period.

A. To assist NFs in converting to the PIRS methodology, a phase-in period shall be provided until June 30, 1992.

B. From October 1, 1990, through June 30, 1991, a NF's prospective operating cost rate shall be a blended rate calculated at 33% of the PIRS operating cost rates determined by § 2.7 above and 67% of the "current" operating rate determined by subsection D below.

C. From July 1, 1991, through June 30, 1992, a NF's prospective operating cost rate shall be a blended rate calculated at 67% of the PIRS operating cost rates determined by § 2.7 above and 33% of the "current" operating rate determined by subsection D below.

D. The following methodology shall be applied to calculate a NF's "current" operating rate:

1. Each NF shall receive as its base "current" operating rate, the weighted average prospective operating cost per diems and efficiency incentive per diems if applicable, calculated by DMAS to be effective September 30, 1990.

2. The base "current" operating rate established above shall be the "current" operating rate for the NF's first partial fiscal year under PIRS. The base "current" operating rate shall be adjusted by appropriate allowance for historical inflation and 50% of the forecasted inflation based on the methodology contained in § 2.7 B at the beginning of each of the NF's fiscal years which starts during the phase-in period, October 1, 1990, through June 30, 1992, to determine the NF's prospective "current" operating rate. See VR 460-03-4.1944 for example calculations.

§ 2.8. Nursing facility rate change.

For the period beginning July 1, 1991, and ending June 30, 1992, the per diem operating rate for each NF shall be adjusted. This shall be accomplished by applying a uniform adjustment factor to the rate of each NF.

Article 3. Allowable Cost Identification.

§ 2.9. Allowable costs.

Costs which are included in rate determination procedures and final settlement shall be only those allowable, reasonable costs which are acceptable under the Medicare principles of reimbursement, except as specifically modified in the Plan and as may be subject to individual or ceiling cost limitations and which are classified in accordance with the DMAS uniform chart of accounts (see VR 460-03-4.1941, Uniform Expense Classification).

A. Certification.

The cost of meeting all certification standards for NF requirements as required by the appropriate state agencies, by state laws, or by federal legislation or regulations.

B. Operating costs.

1. Direct patient care operating costs shall be defined in VR 460-03-4.1941.

2. Allowable direct patient care operating costs shall exclude (i) personal physician fees, and (ii) pharmacy services and prescribed legend and nonlegend drugs provided by nursing facilities which operate licensed in-house pharmacies. These services shall be billed directly to DMAS through separate provider agreements and DMAS shall pay directly in accordance with subsections e and f of Attachment 4.19 B of the State Plan for Medical Assistance (VR 460-02-4.1920).

3. Indirect patient care operating costs include all other operating costs, not identified as direct patient care operating costs and NATCEPs costs in VR 460-03-4.1941, which are allowable under the Medicare principles of reimbursement, except as specifically modified herein and as may be subject to individual cost or ceiling limitations.

C. Allowances/goodwill.

Bad debts, goodwill, charity, courtesy, and all other contractual allowances shall not be recognized as an allowable cost.

D. Cost of protecting employees from blood borne pathogens.

Effective July 1, 1994, reimbursement of allowable costs shall be adjusted in the following way to recognize the costs of complying with requirements of the Occupational Safety and Health Administration (OSHA) for protecting employees against exposure to blood borne pathogens.

1. *Hepatitis B immunization. The statewide median of the reasonable acquisition cost per unit of immunization times the number of immunizations provided to eligible employees during facility fiscal years ending during SFY 1994, divided by Medicaid days in the same fiscal period, shall be added to the indirect peer group ceiling effective July 1, 1994. This increase to the ceilings shall not exceed \$.09 per day for SFY 1995.*

2. *Other OSHA compliance costs. The indirect peer group ceilings shall be increased by \$.07, effective July 1, 1994, to recognize continuing OSHA compliance costs other than immunization.*

3. *Data submission by nursing facilities. Nursing facilities shall provide for fiscal years ending during*

SFY 1994, on forms provided by DMAS, (i) the names, job titles and social security numbers of individuals immunized, the number of immunizations provided to each and the dates of immunization; and (ii) the acquisition cost of immunization.

§ 2.10. Purchases/related organizations.

A. Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control shall be included in the allowable cost of the provider at the cost to the related organization, provided that such costs do not exceed the price of comparable services, facilities or supplies. Purchases of existing NFs by related parties shall be governed by the provisions of § 2.5 B 2.

Allowable cost applicable to management services furnished to the provider by organizations related to the provider by common ownership or control shall be lesser of the cost to the related organization or the per patient day ceiling limitation established for management services cost. (See VR 460-03-4.1943, Cost Reimbursement Limitations.)

B. Related to the provider shall mean that the provider is related by reasons of common ownership or control by the organization furnishing the services, facilities, or supplies.

C. Common ownership exists when an individual or individuals or entity or entities possess significant ownership or equity in the parties to the transaction. Control exists where an individual or individuals or entity or entities have the power, directly or indirectly, significantly to influence or direct the actions or policies of the parties to the transaction. Significant ownership or control shall be deemed to exist where an individual is a "person with an ownership or control interest" within the meaning of 42 CFR 455.101. If the parties to the transaction are members of an immediate family, as defined below, the transaction shall be presumed to be between related parties if the ownership or control by immediate family members, when aggregated together, meets the definitions of "common ownership" or "control," as set forth above. Immediate family shall be defined to include, but not be limited to, the following: (i) husband and wife, (ii) natural parent, child and sibling, (iii) adopted child and adoptive parent, (iv) step-parent, step-child, step-sister, and step-brother, (v) father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law and daughter-in-law, and (vi) grandparent and grandchild.

D. Exception to the related organization principle.

1. Effective with cost reports having fiscal years beginning on or after July 1, 1986, an exception to the related organization principle shall be allowed. Under this exception, charges by a related organization to a provider for goods or services shall be allowable cost to the provider if all four of the conditions set out

below are met.

2. The exception applies if the provider demonstrates by convincing evidence to the satisfaction of DMAS that the following criteria have been met:

a. The supplying organization is a bona fide separate organization. This means that the supplier is a separate sole proprietorship, partnership, joint venture, association or corporation and not merely an operating division of the provider organization.

b. A substantial part of the supplying organization's business activity of the type carried on with the provider is transacted with other organizations not related to the provider and the supplier by common ownership or control and there is an open, competitive market for the type of goods or services furnished by the organization. In determining whether the activities are of similar type, it is important to also consider the scope of the activity.

For example, a full service management contract would not be considered the same type of business activity as a minor data processing contract. The requirement that there be an open, competitive market is merely intended to assure that the item supplied has a readily discernible price that is established through arms-length bargaining by well informed buyers and sellers.

c. The goods or services shall be those which commonly are obtained by institutions such as the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions. This requirement means that institutions such as the provider typically obtain the good or services from outside sources rather than producing the item internally.

d. The charge to the provider is in line with the charge for such services, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such goods or services. The phrase "open market" takes the same meaning as "open, competitive market" in subdivision b above.

3. Where all of the conditions of this exception are met, the charges by the supplier to the provider for such goods or services shall be allowable as costs.

4. This exception does not apply to the purchase, lease or construction of assets such as property, buildings, fixed equipment or major movable equipment. The terms "goods and services" may not be interpreted or construed to mean capital costs associated with such purchases, leases, or construction.

E. Three competitive bids shall not be required for the

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building and fixed equipment components of a construction project outlined in § 2.2. Reimbursement shall be in accordance with § 2.10 A with the limitations stated in § 2.2 B.

§ 2.11. Administrator/owner compensation.

A. Administrators' compensation, whether administrators are owners or non-owners, shall be based on a schedule adopted by DMAS and varied according to facility bed size. The compensation schedule shall be adjusted annually to reflect cost-of-living increases and shall be published and distributed to providers annually. The administrator's compensation schedule covers only the position of administrator and assistants and does not include the compensation of owners employed in capacities other than the NF administrator (see VR 460-03-4.1943, Cost Reimbursement Limitations).

B. Administrator compensation shall mean remuneration paid regardless of the form in which it is paid. This includes, but shall not be limited to, salaries, professional fees, insurance premiums (if the benefits accrue to the employer/owner or his beneficiary) director fees, personal use of automobiles, consultant fees, management fees, travel allowances, relocation expenses in excess of IRS guidelines, meal allowances, bonuses, pension plan costs, and deferred compensation plans. Management fees, consulting fees, and other services performed by owners shall be included in the total compensation if they are performing administrative duties regardless of how such services may be classified by the provider.

C. Compensation for all administrators (owner and nonowner) shall be based upon a 40 hour week to determine reasonableness of compensation.

D. Owner/administrator employment documentation.

1. Owners who perform services for a NF as an administrator and also perform additional duties must maintain adequate documentation to show that the additional duties were performed beyond the normal 40 hour week as an administrator. The additional duties must be necessary for the operation of the NF and related to patient care.

2. Services provided by owners, whether in employee capacity, through management contracts, or through home office relationships shall be compared to the cost and services provided in arms-length transactions.

3. Compensation for such services shall be adjusted where such compensation exceeds that paid in such arms-length transactions or where there is a duplication of duties normally rendered by an administrator. No reimbursement shall be allowed for compensation where owner services cannot be documented and audited.

§ 2.12. Depreciation.

The allowance for depreciation shall be restricted to the straight line method with a useful life in compliance with AHA guidelines. If the item is not included in the AHA guidelines, reasonableness shall be applied to determine useful life.

§ 2.13. Rent/Leases.

Rent or lease expenses shall be limited by the provisions of VR 460-03-4.1942, Leasing of Facilities.

§ 2.14. Provider payments.

A. Limitations.

1. Payments to providers, shall not exceed charges for covered services except for (i) public providers furnishing services free of charge or at a nominal charge (ii) nonpublic provider whose charges are 60% or less of the allowable reimbursement represented by the charges and that demonstrates its charges are less than allowable reimbursement because its customary practice is to charge patients based on their ability to pay. Nominal charge shall be defined as total charges that are 60% or less of the allowable reimbursement of services represented by these charges. Providers qualifying in this section shall receive allowable reimbursement as determined in this Plan.

2. Allowable reimbursement in excess of charges may be carried forward for payment in the two succeeding cost reporting periods. A new provider may carry forward unreimbursed allowable reimbursement in the five succeeding cost reporting periods.

3. Providers may be reimbursed the carry forward to a succeeding cost reporting period (i) if total charges for the services provided in that subsequent period exceed the total allowable reimbursement in that period (ii) to the extent that the accumulation of the carry forward and the allowable reimbursement in that subsequent period do not exceed the providers' direct and indirect care operating ceilings plus allowable plant cost.

B. Payment for service shall be based upon the rate in effect when the service was rendered.

C. For cost reports filed on or after August 1, 1992, an interim settlement shall be made by DMAS within 180 days after receipt and review of the cost report. The 180-day time frame shall similarly apply to cost reports filed but not interim settled as of August 1, 1992. The word "review," for purposes of interim settlement, shall include verification that all financial and other data specifically requested by DMAS is submitted with the cost report. Review shall also mean examination of the cost report and other required submission for obvious errors, inconsistency, inclusion of past disallowed costs, unresolved prior year cost adjustments and a complete signed cost report that conforms to the current DMAS requirements

herein.

New Nursing Facilities.

However, an interim settlement shall not be made when one of the following conditions exists.

1. Cost report filed by a terminated provider;
2. Insolvency of the provider at the time the cost report is submitted;
3. Lack of a valid provider agreement and decertification;
4. Moneys owed to DMAS;
5. Errors or inconsistencies in the cost report; or
6. Incomplete/nonacceptable cost report.

§ 2.15. Legal fees/accounting.

A. Costs claimed for legal/accounting fees shall be limited to reasonable and customary fees for specific services rendered. Such costs must be related to patient care as defined by Medicare principles of reimbursement and subject to applicable regulations herein. Documentation for legal costs must be available at the time of audit.

B. Retainer fees shall be considered an allowable cost up to the limits established in VR 460-03-4.1943, Cost Reimbursement Limitations.

C. As mandated by the Omnibus Budget Reconciliation Act of 1990, effective November 5, 1990, reimbursement of legal expenses for frivolous litigation shall be denied if the action is initiated on or after November 5, 1990. Frivolous litigation is any action initiated by the nursing facility that is dismissed on the basis that no reasonable legal ground existed for the institution of such action.

§ 2.16. Documentation.

Adequate documentation supporting cost claims must be provided at the time of interim settlement, cost settlement, audit, and final settlement.

§ 2.17. Fraud and abuse.

Previously disallowed costs which are under appeal and affect more than one cost reporting period shall be disclosed in subsequent cost reports if the provider wishes to reserve appeal rights for such subsequent cost reports. The reimbursement effect of such appealed costs shall be computed by the provider and submitted to DMAS with the cost report. Where such disclosure is not made to DMAS, the inclusion of previously disallowed costs may be referred to the Medicaid Fraud Control Unit of the Office of the Attorney General.

Article 4.

§ 2.18. Interim rate.

A. For all new or expanded NFs the 95% occupancy requirement shall be waived for establishing the first cost reporting period interim rate. This first cost reporting period shall not exceed 12 months from the date of the NF's certification.

B. Upon a showing of good cause, and approval of the DMAS, an existing NF that expands its bed capacity by 50% or more shall have the option of retaining its prospective rate, or being treated as a new NF.

C. The 95% occupancy requirement shall be applied to the first and subsequent cost reporting periods' actual costs for establishing such NF's second and future cost reporting periods' prospective reimbursement rates. The 95% occupancy requirement shall be considered as having been satisfied if the new NF achieved a 95% occupancy at any point in time during the first cost reporting period.

D. A new NF's interim rate for the first cost reporting period shall be determined based upon the lower of its anticipated allowable cost determined from a detailed budget (or pro forma cost report) prepared by the provider and accepted by the DMAS, or the appropriate operating ceilings or charges.

E. On the first day of its second cost reporting period, a new nursing facility's interim plant rate shall be converted to a per diem amount by dividing it by the number of patient days computed as 95% of the daily licensed bed complement during the first cost reporting period.

E. F. Any NF receiving reimbursement under new NF status shall not be eligible to receive the blended phase-in period rate under § 2.8.

F. G. During its first semiannual period of operation, a newly constructed or newly enrolled NF shall have an assigned SII based upon its peer group's average SII for direct patient care. An expanded NF receiving new NF treatment shall receive the SII calculated for its last semiannual period prior to obtaining new NF status.

§ 2.19. Final rate.

The DMAS shall reimburse the lower of the appropriate operating ceilings, charges or actual allowable cost for a new NF's first cost reporting period of operation, subject to the procedures outlined above in § 2.18 A, C, E, and F.

Upon determination of the actual allowable operating cost for direct patient care and indirect patient care the per diem amounts shall be used to determine if the provider is below the peer group ceiling used to set its interim rate. If costs are below those ceilings, an efficiency incentive shall be paid at settlement of the first

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year cost report.

This incentive will allow a NF to be paid up to 25% of the difference between its actual allowable operating cost and the peer group ceiling used to set the interim rate. (Refer to § 2.7 F.)

Article 5. Cost Reports.

§ 2.20. Cost report submission.

A. Cost reports are due not later than 90 days after the provider's fiscal year end. If a complete cost report is not received within 90 days after the end of the provider's fiscal year, it is considered delinquent. The cost report shall be deemed complete for the purpose of cost settlement when DMAS has received all of the following, with the exception that the audited financial statements required by subdivisions 3 a and 6 b of this subsection shall be considered timely filed if received not later than 120 days after the provider's fiscal year end:

1. Completed cost reporting form(s) provided by DMAS, with signed certification(s);
2. The provider's trial balance showing adjusting journal entries;
3. a. The provider's audited financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), a statement of cash flows, the auditor's report in which he expresses his opinion or, if circumstances require, disclaims an opinion based on generally accepted auditing standards, footnotes to the financial statements, and the management report. Multi-facility providers shall be governed by § 2.20 A 6;

b. Schedule of restricted cash funds that identify the purpose of each fund and the amount;
- c. Schedule of investments by type (stock, bond, etc.), amount, and current market value;
4. Schedules which reconcile financial statements and trial balance to expenses claimed in the cost report;
5. Depreciation schedule ;
6. NFs which are part of a chain organization must also file:
 - a. Home office cost report;
 - b. Audited consolidated financial statements of the chain organization including the auditor's report in which he expresses his opinion or, if circumstances require, disclaims an opinion based on generally accepted auditing standards, the management report

and footnotes to the financial statements;

c. The NFs financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), and a statement of cash flows;

d. Schedule of restricted cash funds that identify the purpose of each fund and the amount;

e. Schedule of investments by type (stock, bond, etc.), amount, and current market value; and

7. Such other analytical information or supporting documentation that may be required by DMAS.

B. When cost reports are delinquent, the provider's interim rate shall be reduced by 20% the first month and an additional 20% of the original interim rate for each subsequent month the report has not been submitted. DMAS shall notify the provider of the schedule of reductions which shall start on the first day of the following month. For example, for a September 30 fiscal year end, notification will be mailed in early January stating that payments will be reduced starting with the first payment in February.

C. After the overdue cost report is received, desk reviewed, and a new prospective rate established, the amounts withheld shall be computed and paid. If the provider fails to submit a complete cost report within 180 days after the fiscal year end, a penalty in the amount of 10% of the balance withheld shall be forfeited to DMAS.

§ 2.21. Reporting form.

All cost reports shall be submitted on uniform reporting forms provided by the DMAS, or by Medicare if applicable. Such cost reports, subsequent to the initial cost report period, shall cover a 12-month period. Any exceptions must be approved by the DMAS.

§ 2.22. Accounting method.

The accrual method of accounting and cost reporting is mandated for all providers.

§ 2.23. Cost report extensions.

A. Extension for submission of a cost report may be granted if the provider can document extraordinary circumstances beyond its control.

B. Extraordinary circumstances do not include:

1. Absence or changes of chief finance officer, controller or bookkeeper;
2. Financial statements not completed;
3. Office or building renovations;

4. Home office cost report not completed;
5. Change of stock ownership;
6. Change of intermediary;
7. Conversion to computer; or
8. Use of reimbursement specialist.

§ 2.24. Fiscal year changes.

All fiscal year end changes must be approved 90 days prior to the beginning of a new fiscal year.

Article 6. Prospective Rates.

§ 2.25. Time frames.

A. For cost reports filed on or after August 1, 1992, a prospective rate shall be determined by DMAS within 90 days of the receipt of a complete cost report. (See § 2.20 A.) The 180-day time frame shall similarly apply to cost reports filed but for which a prospective rate has not been set as of August 1, 1992. Rate adjustments shall be made retroactive to the first day of the provider's new cost reporting year. Where a field audit is necessary to set a prospective rate, the DMAS shall have an additional 90 days to determine any appropriate adjustments to the prospective rate as a result of such field audit. This time period shall be extended if delays are attributed to the provider.

B. Subsequent to establishing the prospective rate DMAS shall conclude the desk audit of a providers' cost report and determine if further field audit activity is necessary. The DMAS will seek repayment or make retroactive settlements when audit adjustments are made to costs claimed for reimbursement.

Article 7. Retrospective rates.

§ 2.26. The retrospective method of reimbursement shall be used for Mental Health/Mental Retardation facilities.

§ 2.27. (reserved)

Article 8. Record Retention.

§ 2.28. Time frames.

A. All of the NF's accounting and related records, including the general ledger, books of original entry, and statistical data must be maintained for a minimum of five years, or until all affected cost reports are final settled.

B. Certain information must be maintained for the duration of the provider's participation in the DMAS and

until such time as all cost reports are settled. Examples of such information are set forth in § 2.29.

§ 2.29. Types of records to be maintained.

Information which must be maintained for the duration of the provider's participation in the DMAS includes, but is not limited to:

1. Real and tangible property records, including leases and the underlying cost of ownership;
2. Itemized depreciation schedules;
3. Mortgage documents, loan agreements, and amortization schedules;
4. Copies of all cost reports filed with the DMAS together with supporting financial statements.

§ 2.30. Record availability.

The records must be available for audits by DMAS staff. Where such records are not available, costs shall be disallowed.

Article 9. Audits.

§ 2.31. Audit overview.

Desk audits shall be performed to verify the completeness and accuracy of the cost report, and reasonableness of costs claimed for reimbursement. Field audits, as determined necessary by the DMAS, shall be performed on the records of each participating provider to determine that costs included for reimbursement were accurately determined and reasonable, and do not exceed the ceilings or other reimbursement limitations established by the DMAS.

§ 2.32. Scope of audit.

The scope of the audit includes, but shall not be limited to: trial balance verification, analysis of fixed assets, indebtedness, selected revenues, leases and the underlying cost of ownership, rentals and other contractual obligations, and costs to related organizations. The audit scope may also include various other analyses and studies relating to issues and questions unique to the NF and identified by the DMAS. Census and related statistics, patient trust funds, and billing procedures are also subject to audit.

§ 2.33. Field audit requirements.

Field audits shall be required as follows:

1. For the first cost report on all new NF's.
2. For the first cost report in which costs for bed

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additions or other expansions are included.

3. When a NF is sold, purchased, or leased.

4. As determined by DMAS desk audit.

§ 2.34. Provider notification.

The provider shall be notified in writing of all adjustments to be made to a cost report resulting from desk or field audit with stated reasons and references to the appropriate principles of reimbursement or other appropriate regulatory cites.

§ 2.35. Field audit exit conference.

A. The provider shall be offered an exit conference to be executed within 15 days following completion of the on-site audit activities, unless other time frames are mutually agreed to by the DMAS and provider. Where two or more providers are part of a chain organization or under common ownership, DMAS shall have up to 90 days after completion of all related on-site audit activities to offer an exit conference for all such NFs. The exit conference shall be conducted at the site of the audit or at a location mutually agreeable to the DMAS and the provider.

B. The purpose of the exit conference shall be to enable the DMAS auditor to discuss such matters as the auditor deems necessary, to review the proposed field audit adjustments, and to present supportive references. The provider will be given an opportunity during the exit conference to present additional documentation and agreement or disagreement with the audit adjustments.

C. All remaining adjustments, including those for which additional documentation is insufficient or not accepted by the DMAS, shall be applied to the applicable cost report(s) regardless of the provider's approval or disapproval.

D. The provider shall sign an exit conference form that acknowledges the review of proposed adjustments.

E. After the exit conference the DMAS shall perform a review of all remaining field audit adjustments. Within a reasonable time and after all documents have been submitted by the provider, the DMAS shall transmit in writing to the provider a final field audit adjustment report (FAAR), which will include all remaining adjustments not resolved during the exit conference. The provider shall have 15 days from the date of the letter which transmits the FAAR, to submit any additional documentation which may affect adjustments in the FAAR.

§ 2.36. Audit delay.

In the event the provider delays or refuses to permit an audit to occur or to continue or otherwise interferes with the audit process, payments to the provider shall be reduced as stated in § 2.20 B.

§ 2.37. Field audit time frames.

A. If a field audit is necessary after receipt of a complete cost report, such audit shall be initiated within three years following the date of the last notification of program reimbursement and the on site activities, including exit conferences, shall be concluded within 180 days from the date the field audit begins. Where audits are performed on cost reports for multiple years or providers, the time frames shall be reasonably extended for the benefit of the DMAS and subject to the provisions of § 2.35.

B. Documented delays on the part of the provider will automatically extend the above time frames to the extent of the time delayed.

C. Extensions of the time frames shall be granted to the department for good cause shown.

D. Disputes relating to the timeliness established in §§ 2.35 and 2.37, or to the grant of extensions to the DMAS, shall be resolved by application to the Director of the DMAS or his designee.

PART III. APPEALS.

§ 3.1. Dispute resolution for nonstate operated nursing facilities.

A. NF's have the right to appeal the DMAS's interpretation and application of state and federal Medicaid and applicable Medicare principles of reimbursement in accordance with the Administrative Process Act, § 9-6.14.1 et seq. and § 32.1-325.1 of the Code of Virginia.

B. Nonappealable issues.

1. The use of state and federal Medicaid and applicable Medicare principles of reimbursement.

2. The organization of participating NF's into peer groups according to location as a proxy for cost variation across facilities with similar operating characteristics. The use of individual ceilings as a proxy for determining efficient operation within each peer group.

3. Calculation of the initial peer group ceilings using the most recent cost settled data available to DMAS that reflects NF operating costs inflated to September 30, 1990.

4. The use of the moving average of the Skilled Nursing Facility market basket of routine service costs, as developed by Data Resources, Incorporated, adjusted for Virginia, as the prospective escalator.

5. The establishment of separate ceilings for direct

operating costs and indirect operating costs.

6. The use of Service Intensity Indexes to identify the resource needs of given NFs patient mix relative to the needs present in other NFs.

7. The development of Service Intensity Indexes based on:

a. Determination of resource indexes for each patient class that measures relative resource cost.

b. Determination of each NF's average relative resource cost index across all patients.

c. Standardizing the average relative resource cost indexes of each NF across all NF's.

8. The use of the DMAS Long Term Care Information System (LTCIS), assessment form (currently DMAS-95), Virginia Center on Aging Study, the State of Maryland Time and Motion Study of the Provision of Nursing Service in Long Term Care Facilities, and the KPMG Peat Marwick Survey of Virginia long-term care NF's nursing wages to determine the patient class system and resource indexes for each patient class.

9. The establishment of payment rates based on service intensity indexes.

§ 3.2. Conditions for appeal.

[A.] An appeal shall not be heard until the following conditions are met:

1. Where appeals result from desk or field audit adjustments, the provider shall have received a notification of program reimbursement (NPR) in writing from the DMAS.

2. Any and all moneys due to DMAS shall be paid in full, unless a repayment plan has been agreed to by the Director of the Division of Cost Settlement and Audit.

3. All first level appeal requests shall be filed in writing with the DMAS within 90 business days following the date of a DMAS notice of program reimbursement that adjustments have been made to a specific cost report.

§ 3.3. Appeal procedure.

A. There shall be two levels of administrative appeal.

B. Informal appeals shall be decided by the Director of the Division of Cost Settlement and Audit after an informal fact finding conference is held. The decision of the Director of Cost Settlement and Audit shall be sent in writing to the provider within 90 business days following conclusion of the informal fact finding conference.

C. If the provider disagrees with such initial decision the provider may, at its discretion, file a notice of appeal to the Director of the DMAS. Such notice shall be in writing and filed within 30 business days of the date of the initial decision.

D. Within 30 business days of the date of such notice of appeal, the director shall appoint a hearing officer to conduct the proceedings, to review the issues and the evidence presented, and to make a written recommendation.

E. The director shall notify the provider of his final decision within 30 business days of the date of the appointed hearing officer's written recommendation, or after the parties have filed exceptions to the recommendations, whichever is later.

F. The director's final written decision shall conclude the provider's administrative appeal.

§ 3.4. Formal hearing procedures.

Formal hearing procedures, as developed by DMAS, shall control the conduct of the formal administrative proceedings.

§ 3.5. Appeals time frames.

Appeal time frames noted throughout this section may be extended for the following reasons;

A. The provider submits a written request prior to the due date requesting an extension for good cause and the DMAS approves the extension.

B. Delays on the part of the NF documented by the DMAS shall automatically extend DMAS's time frame to the extent of the time delayed.

C. Extensions of time frames shall be granted to the DMAS for good cause shown.

D. When appeals for multiple years are submitted by a NF or a chain organization or common owners are coordinating appeals for more than one NF, the time frames shall be reasonably extended for the benefit of the DMAS.

E. Disputes relating to the time lines established in § 3.3 B or to the grant of extensions to the DMAS shall be resolved by application to the Director of the DMAS or his designee.

§ 3.6. Dispute resolution for state-operated NFs.

A. Definitions.

"DMAS" means the Department of Medical Assistance Services.

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"Division director" means the director of a division of DMAS.

"State-operated provider" means a provider of Medicaid services which is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

B. Right to request reconsideration.

1. A state-operated provider shall have the right to request a reconsideration for any issue which would be otherwise administratively appealable under the State Plan by a nonstate operated provider. This shall be the sole procedure available to state-operated providers.

2. The appropriate DMAS division must receive the reconsideration request within 30 business days after the date of a DMAS Notice of Amount of Program Reimbursement, notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute.

C. Informal review.

The state-operated provider shall submit to the appropriate DMAS division written information specifying the nature of the dispute and the relief sought. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought; the amount of the adjustment sought; and the reasons for seeking the adjustment. The division director or his designee shall review this information, requesting additional information as necessary. If either party so requests, they may meet to discuss a resolution. Any designee shall then recommend to the division director whether relief is appropriate in accordance with applicable law and regulations.

D. Division director action.

The division director shall consider any recommendation of his designee and shall render a decision.

E. DMAS director review.

A state-operated provider may, within 30 business days after the date of the informal review decision of the division director, request that the DMAS Director or his designee review the decision of the division director. The DMAS Director shall have the authority to take whatever measures he deems appropriate to resolve the dispute.

F. Secretarial review.

If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 business days after the date of the decision of the DMAS Director, the provider may request the DMAS director to refer the matter to the Secretary of Health and Human Resources and any other cabinet secretary as appropriate. Any determination by such secretary or secretaries shall

be final.

PART IV. INDIVIDUAL EXPENSE LIMITATION.

In addition to operating costs being subject to peer group ceilings, costs are further subject to maximum limitations as defined in VR 460-03-4.1943, Cost Reimbursement Limitations.

PART V. COST REPORT PREPARATION INSTRUCTIONS.

Instructions for preparing NF cost reports will be provided by the DMAS.

PART VI. STOCK TRANSACTIONS.

§ 6.1. Stock acquisition.

The acquisition of the capital stock of a provider does not constitute a basis for revaluation of the provider's assets. Any cost associated with such an acquisition shall not be an allowable cost. The provider selling its stock continues as a provider after the sale, and the purchaser is only a stockholder of the provider.

§ 6.2. Merger of unrelated parties.

A. In the case of a merger which combines two or more unrelated corporations under the regulations of the Code of Virginia, there will be only one surviving corporation. If the surviving corporation, which will own the assets and liabilities of the merged corporation, is not a provider, a Certificate of Public Need, if applicable, must be issued to the surviving corporation.

B. The nonsurviving corporation shall be subject to the policies applicable to terminated providers, including those relating to gain or loss on sales of NFs.

§ 6.3. Merger of related parties.

The statutory merger of two or more related parties or the consolidation of two or more related providers resulting in a new corporate entity shall be treated as a transaction between related parties. No revaluation shall be permitted for the surviving corporation.

PART VII. NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAM AND COMPETENCY EVALUATION PROGRAMS (NATCEPs).

§ 7.1. The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) amended § 1903(a)(2)(B) of the Social Security Act to fund actual NATCEPs costs incurred by NFs separately from the NF's medical assistance services reimbursement rates.

§ 7.2. NATCEPs costs.

A. NATCEPs costs shall be as defined in VR 460-03-4.1941.

B. To calculate the reimbursement rate, NATCEPs costs contained in the most recently filed cost report shall be converted to a per diem amount by dividing allowable NATCEPs costs by the actual number of NF's patient days.

C. The NATCEPs interim reimbursement rate determined in § 7.2 B shall be added to the prospective operating cost and plant cost components or charges, whichever is lower, to determine the NF's prospective rate. The NATCEPs interim reimbursement rate shall not be adjusted for inflation.

D. Reimbursement of NF costs for training and competency evaluation of nurse aides must take into account the NF's use of trained nurse aides in caring for Medicaid, Medicare and private pay patients. Medicaid shall not be charged for that portion of NATCEPs costs which are properly charged to Medicare or private pay services. The final retrospective reimbursement for NATCEPs costs shall be the reimbursement rate as calculated from the most recently filed cost report by the methodology in § 7.2 B times the Medicaid patient days from the DMAS MMR-240.

E. Disallowance of nonreimbursable NATCEPs costs shall be reflected in the year in which the nonreimbursable costs were claimed.

F. Payments to providers for allowable NATCEPs costs shall not be considered in the comparison of the lower allowable reimbursement or charges for covered services, as outlined in § 2.14 A.

PART VIII.

(Reserved)

CRIMINAL RECORDS CHECKS FOR NURSING FACILITY EMPLOYEES.

§ 8.1. Criminal records checks.

A. This section implements the requirements of § 32.1-126.01 of the Code of Virginia and Chapter 994 of the Acts of Assembly of 1993 (Item 313 T).

B. A licensed nursing facility shall not hire for compensated employment persons who have been convicted of:

1. Murder;

2. Abduction for immoral purposes as set out in § 18.2-48 of the Code of Virginia;

3. Assaults and bodily woundings as set out in Article 4 (§ 18.2-51 et seq.) of Chapter 4 of Title 18.2 of the Code of Virginia;

4. Arson as set out in Article 1 (§ 18.2-77 et seq.) of Chapter 5 of Title 18.2 of the Code of Virginia;

5. Pandering as set out in § 18.2-355 of the Code of Virginia;

6. Crimes against nature involving children as set out in § 18.2-361 of the Code of Virginia;

7. Taking indecent liberties with children as set out in §§ 18.2-370 or 18.2-370.1 of the Code of Virginia;

8. Abuse and neglect of children as set out in § 18.2-371.1 of the Code of Virginia;

9. Failure to secure medical attention for an injured child as set out in § 18.2-314 of the Code of Virginia;

10. Obscenity offenses as set out in § 18.2-374.1 of the Code of Virginia; or

11. Abuse or neglect of an incapacitated adult as set out in § 18.2-369 of the Code of Virginia.

C. The provider shall obtain a sworn statement or affirmation from every applicant disclosing any criminal convictions or pending criminal charges for any of the offenses specified in subsection B regardless of whether the conviction or charges occurred in the Commonwealth.

D. The provider shall obtain an original criminal record clearance or an original criminal record history from the Central Criminal Records Exchange for every person hired. This information shall be obtained within 30 days from the date of employment and maintained in the employees' files during the term of employment and for a minimum of five years after employment terminates for whatever reason.

E. The provider may hire an applicant whose misdemeanor conviction is more than five years old and whose conviction did not involve abuse or neglect or moral turpitude.

F. Reimbursement to the provider [~~shall~~ will] be handled through the cost reporting form provided by the DMAS and will [] be limited to the actual charges made by the Central Criminal Records Exchange for the records requested. Such actual charges [~~shall~~ will] be a pass-through cost which is not a part of the operating or plant cost components.

PART IX. USE OF MMR-240.

All providers must use the data from computer printout MMR-240 based upon a 60-day accrual period.

PART X. COMMINGLED INVESTMENT INCOME.

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DMAS shall treat funds commingled for investment purposes in accordance with PRM-15, § 202.6.

PART XI. PROVIDER NOTIFICATION.

DMAS shall notify providers of State Plan changes affecting reimbursement 30 days prior to the enactment of such changes.

PART XII. START-UP COSTS AND ORGANIZATIONAL COSTS.

§ 12.1. Start-up costs.

A. In the period of developing a provider's ability to furnish patient care services, certain costs are incurred. The costs incurred during this time of preparation are referred to as start-up costs. Since these costs are related to patient care services rendered after the time of preparation, they shall be capitalized as deferred charges and amortized over a 60-month time frame.

B. Start-up costs may include, but are not limited to, administrative and nursing salaries; heat, gas, and electricity; taxes, insurance; employee training costs; repairs and maintenance; housekeeping; and any other allowable costs incident to the start-up period. However, any costs that are properly identifiable as operating costs must be appropriately classified as such and excluded from start-up costs.

C. Start-up costs that are incurred immediately before a provider enters the Program and that are determined by the provider, subject to the DMAS approval, to be immaterial need not be capitalized but rather may be charged to operations in the first cost reporting period.

D. Where a provider incurs start-up costs while in the Program and these costs are determined by the provider, subject to the DMAS approval, to be immaterial, these costs shall not be capitalized but shall be charged to operations in the periods incurred.

§ 12.2. Applicability.

A. Start-up cost time frames.

1. Start-up costs are incurred from the time preparation begins on a newly constructed or purchased building, wing, floor, unit, or expansion thereof to the time the first patient (whether Medicaid or non-Medicaid) is admitted for treatment, or where the start-up costs apply only to nonrevenue producing patient care functions or nonallowable functions, to the time the areas are used for their intended purposes.

2. If a provider intends to prepare all portions of its entire facility at the same time, start-up costs for all portions of the facility shall be accumulated in a single deferred charge account and shall be amortized

when the first patient is admitted for treatment.

3. If a provider intends to prepare portions of its facility on a piecemeal basis (i.e., preparation of a floor or wing of a provider's facility is delayed), start-up costs shall be capitalized and amortized separately for the portion or portions of the provider's facility prepared during different time periods.

4. Moreover, if a provider expands its NF by constructing or purchasing additional buildings or wings, start-up costs shall be capitalized and amortized separately for these areas.

B. Depreciation time frames.

1. Costs of the provider's facility and building equipment shall be depreciated using the straight line method over the lives of these assets starting with the month the first patient is admitted for treatment.

2. Where portions of the provider's NF are prepared for patient care services after the initial start-up period, those asset costs applicable to each portion shall be depreciated over the remaining lives of the applicable assets. If the portion of the NF is a nonrevenue-producing patient care area or nonallowable area, depreciation shall begin when the area is opened for its intended purpose. Costs of major movable equipment, however, shall be depreciated over the useful life of each item starting with the month the item is placed into operation.

§ 12.3. Organizational costs.

A. Organizational costs are those costs directly incident to the creation of a corporation or other form of business. These costs are an intangible asset in that they represent expenditures for rights and privileges which have a value to the enterprise. The services inherent in organizational costs extend over more than one accounting period and thus affect the costs of future periods of operations.

B. Allowable organizational costs shall include, but not be limited to, legal fees incurred in establishing the corporation or other organization (such as drafting the corporate charter and by-laws, legal agreements, minutes of organizational meeting, terms of original stock certificates), necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stockholders and fees paid to states for incorporation.

C. The following types of costs shall not be considered allowable organizational costs: costs relating to the issuance and sale of shares of capital stock or other securities, such as underwriters fees and commissions, accountant's or lawyer's fees, cost of qualifying the issues with the appropriate state or federal authorities, stamp taxes, etc.

D. Allowable organization costs shall generally be

capitalized by the organization. However, if DMAS concludes that these costs are not material when compared to total allowable costs, they may be included in allowable indirect operating costs for the initial cost reporting period. In all other circumstances, allowable organization costs shall be amortized ratably over a period of 60 months starting with the month the first patient is admitted for treatment.

PART XIII. DMAS AUTHORIZATION.

§ 13.1. Access to records.

A. DMAS shall be authorized to request and review, either through a desk or field audit, all information related to the provider's cost report that is necessary to ascertain the propriety and allocation of costs (in accordance with Medicare and Medicaid rules, regulations, and limitations) to patient care and nonpatient care activities.

B. Examples of such information shall include, but not be limited to, all accounting records, mortgages, deeds, contracts, meeting minutes, salary schedules, home office services, cost reports, and financial statements.

C. This access also applies to related organizations as defined in § 2.10 who provide assets and other goods and services to the provider.

PART XIV. HOME OFFICE COSTS.

§ 14.1. General.

Home office costs shall be allowable to the extent they are reasonable, relate to patient care, and provide cost savings to the provider.

§ 14.2. Purchases.

Provider purchases from related organizations, whether for services, or supplies, shall be limited to the lower of the related organizations actual cost or the price of comparable purchases made elsewhere.

§ 14.3. Allocation of home office costs.

Home office costs shall be allocated in accordance with § 2150.3, PRM-15.

§ 14.4. Nonrelated management services.

Home office costs associated with providing management services to nonrelated entities shall not be recognized as allowable reimbursable cost.

§ 14.5. Allowable and nonallowable home office costs.

Allowable and nonallowable home office costs shall be

recognized in accordance with § 2150.2, PRM-15.

§ 14.6. Equity capital.

Item 398 D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers for periods or portions thereof on or after July 1, 1987.

PART XV. REFUND OF OVERPAYMENTS.

§ 15.1. Lump sum payment.

When the provider files a cost report indicating that an overpayment has occurred, full refund shall be remitted with the cost report. In cases where DMAS discovers an overpayment during desk audit, field audit, or final settlement, DMAS shall promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken even though the provider disputes in whole or in part DMAS' determination of the overpayment.

§ 15.2. Offset.

If the provider has been overpaid for a particular fiscal year and has been underpaid for another fiscal year, the underpayment shall be offset against the overpayment. So long as the provider has an overpayment balance, any underpayments discovered by subsequent review or audit shall be used to reduce the balance of the overpayment.

§ 15.3. Payment schedule.

A. If the provider cannot refund the total amount of the overpayment (i) at the time it files a cost report indicating that an overpayment has occurred, the provider shall request in writing an extended repayment schedule at the time of filing, or (ii) within 30 days after receiving the DMAS demand letter, the provider shall promptly request in writing an extended repayment schedule.

B. DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, if a provider demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of DMAS may approve a repayment schedule of up to 36 months.

C. A provider shall have no more than one extended repayment schedule in place at one time. If subsequent audits identify additional overpayment, the full amount shall be repaid within 30 days unless the provider submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amounts.

D. If, during the time an extended repayment schedule is in effect, the provider ceases to be a participating provider or fails to file a cost report in a timely manner, the outstanding balance shall become immediately due and

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payable.

E. When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered from interim payments to the provider or by lump sum payments.

§ 15.4. Extension request documentation.

In the written request for an extended repayment schedule, the provider shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the provider written notification of the approved repayment schedule, which shall be effective retroactive to the date the provider submitted the proposal.

§ 15.5. Interest charge on extended repayment.

A. Once an initial determination of overpayment has been made, DMAS shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the initial determination of overpayment. If an appeal follows, interest shall be waived during the period of administrative appeal of an initial determination of overpayment.

B. Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 of the Code of Virginia from the date the director's determination becomes final.

C. The director's determination shall be deemed to be final on (i) the due date of any cost report filed by the provider indicating that an overpayment has occurred, or (ii) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (iii) the issue date of any administrative decision issued by DMAS after an informal fact finding conference, if the provider does not file an appeal, or (iv) the issue date of any administrative decision signed by the director, regardless of whether a judicial appeal follows. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the provider shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the provider paid to DMAS.

PART XVI. REVALUATION OF ASSETS.

§ 16.1. Change of ownership.

A. Under the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, reimbursement for capital upon the change of ownership of a NF is restricted to the lesser of:

1. One-half of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership), in the Dodge Construction Cost Index applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year, or

2. One-half of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Consumer Price Index for All Urban Consumers (CPI-U) applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year.

B. To comply with the provisions of COBRA 1985, effective October 1, 1986, the DMAS shall separately apply the following computations to the capital assets of each facility which has undergone a change of ownership:

1. One-half of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership), in the Dodge Construction Cost Index, or

2. One-half of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Consumer Price Index for All Urban Consumers (CPI-U).

C. Change of ownership is deemed to have occurred only when there has been a bona fide sale of assets of a NF (See § 2.5 B 3 for the definition of "bona fide" sale).

D. Reimbursement for capital assets which have been revalued when a facility has undergone a change of ownership shall be limited to the lesser of:

1. The amounts computed in subsection B above;
2. Appraised replacement cost value; or
3. Purchase price.

E. Date of acquisition is deemed to have occurred on the date legal title passed to the seller. If a legal titling date is not determinable, date of acquisition shall be considered to be the date a certificate of occupancy was issued by the appropriate licensing or building inspection agency of the locality where the nursing facility is located.

VR 460-03-4.1941. Uniform Expense Classification.

§ 1. Foreword.

The attached is the classification of expenses applicable to the Nursing Facility Payment System.

Allowable expenses shall meet all of the following requirements; necessity, reasonableness, nonduplication, related to patient care, not exceeding the limits or ceilings

established in the Payment System and meet applicable Medicare principles of reimbursement.

§ 2. Direct patient care operating costs.

A. Nursing service expenses.

1. **Salary-Nursing Administration.** Gross salary (includes sick pay, holiday pay, vacation pay, staff development pay and overtime pay) of all licensed nurses in supervisory positions defined as follows (Director of Nursing, Assistant Director of Nursing, nursing unit supervisors and patient care coordinators).

2. **Salaries - RNs.** Gross salary of registered nurses.

3. **Salaries - LPNs.** Gross salary of licensed practical nurses.

4. **Salaries - Nurse Aides.** Gross salary of certified nurse aides.

5. **Nursing Employee Benefits.** Benefits related to registered nurses, licensed practical nurses, certified nurse aides and nursing administration personnel as defined in subdivision A 1 of this section. See § 3 B for description of employee benefits.

6. **Contract Nursing Services.** Cost of registered nurses, licensed practical nurses and certified nurse aides on a contract basis.

7. **Supplies.** Cost of supplies, including nursing and charting forms, medication and treatment records, physician order forms.

8. **Professional Fees.** Medical director and pharmacy consultant fees.

B. Minor medical and surgical supplies.

1. **Salaries - Medical Supply.** Gross salary of personnel responsible for procurement, inventory and distribution of minor medical and surgical supplies.

2. **Medical Supply Employee Benefits.** Benefits related to medical supply personnel. See § 3 B for description of employee benefits.

3. **Supplies.** Cost of items for which a separate identifiable charge is not customarily made, including but not limited to, colostomy bags; dressings; chux; rubbing alcohol; syringes; patient gowns; basins; bed pans; ice-bags and canes, crutches, walkers, wheelchairs, traction equipment and other durable medical equipment for multi-patient use.

4. **Oxygen.** Cost of oxygen for which a separate charge is not customarily made.

5. **Nutrient/Tube Feedings.** Cost of nutrients for tube

feedings.

C. Ancillary service cost.

Allowable ancillary service costs represents gross salary and related employee benefits of those employees engaged in covered ancillary services to Medicaid recipients, cost of all supplies used by the respective ancillary service departments, cost of ancillary services performed on a contract basis by other than employees and all other costs allocated to the ancillary service cost centers in accordance with Medicare principles of reimbursement. Following is a listing of all covered ancillary services:

1. Radiology

2. Laboratory

3. Inhalation Therapy

4. Physical Therapy

5. Occupational Therapy

6. Speech Therapy

7. EKG

8. EEG

9. Medical Supplies Charged to Patient

§ 3. Indirect patient care operating costs.

A. Administrative and general.

1. **Administrator/Owner Assistant Administrator.** Compensation of individuals responsible for administering the operations of the nursing facility. (See § 2.11 of VR 460-03-4.1940:1, Nursing Home Payment System, and VR 460-03-4.1943, Cost Reimbursement Limitations, for limitations).

2. **Other Administrative and Fiscal Services.** Gross salaries of all personnel in administrative, personnel, fiscal, billing and admitting, communications and purchasing departments.

3. **Management Fees.** Cost of fees for providing necessary management services related to nursing facility operations. (See VR 460-03-4.1943, Cost Reimbursement Limitations, for limitations).

4. **Professional Fees - Accounting.** Fees paid to independent outside auditors and accountants.

5. **Professional Fees - Legal.** Fees paid to attorneys (See VR 460-03-4.1943, Cost Reimbursement Limitations, for limitations).

6. **Professional Fees - Other.** Fees, other than

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accounting or legal, for professional services related to nursing facility patient care.

7. Director's Fees. Fees paid for attendance at scheduled meetings which serve as reimbursement for time, travel, and services provided. (See VR 460-03-4.1943, Cost Reimbursement Limitations, for limitations.)

8. Membership Fees. Fees related to membership in health care organizations which promote objectives in the providers' field of health care activities (See VR 460-03-4.1943, Cost Reimbursement Limitations, for limitations).

9. Advertising (Classified). Cost of advertising to recruit new employees and yellow page advertising.

10. Public Relations. Cost of promotional expenses including brochures and other informational documents regarding the nursing facility.

11. Telephone. Cost of telephone service used by employees of the nursing facility.

12. Subscriptions. Cost of subscribing to newspapers, magazines and periodicals.

13. Office Supplies. Cost of supplies used in administrative departments (e.g., pencils, papers, erasers, staples).

14. Minor furniture and equipment. Cost of furniture and equipment which does not qualify as a capital asset.

15. Printing and Postage. Cost of reproducing documents which are reasonable, necessary and related to nursing facility patient care and cost of postage and freight charges.

16. Travel. Cost of travel (airfare, auto mileage, lodging, meals, etc. by administrator or other authorized personnel on official nursing facility business). (See VR 460-03-4.1943, Cost Reimbursement Limitations, for limitations).

17. Auto. All costs of maintaining nursing facility vehicles, including gas, oil, tires, licenses, maintenance of such vehicles.

18. License Fees. Fees for licenses, including state, county, and local business licenses, and VHSCRC filing fees.

19. Liability Insurance. Cost of insuring the facility against liability claims.

20. Interest. Other than mortgage and equipment.

21. Amortization/Start-Up Costs. Amortization of

allowable Start-Up Costs (See § 12.1 of the Nursing Home Payment System).

22. Amortization/Organizational Costs. Amortization of allowable organization costs (see § 12.3 of the Nursing Home Payment System).

B. Employee benefits.

1. FICA (Social Security). Cost of employer's portion of Social Security Tax.

2. State Unemployment. State Unemployment Insurance Costs.

3. Federal Unemployment. Federal Unemployment Insurance Costs.

4. Workers' Compensation. Cost of Workers' Compensation Insurance.

5. Health Insurance. Cost of employer's contribution to employee health insurance.

6. Group Life Insurance. Cost of employer's contribution to employee Group Life Insurance.

7. Pension Plan. Employer's cost of providing pension program for employees.

8. Other employee benefits. Cost of awards and recognition ceremonies for recognition and incentive programs, disability insurance, child care, and other commonly offered employee benefits which are nondiscriminatory.

C. Dietary expenses.

1. Salaries. Gross salary of kitchen personnel, including dietary supervisor, cooks, helpers, and dishwashers.

2. Supplies. Cost of items such as soap, detergent, napkins, paper cups, and straws.

3. Dishes and Utensils. Cost of knives, forks, spoons, plates, cups, saucers, bowls and glasses.

4. Consultants. Fees paid to consulting dietitians.

5. Purchased Services. Costs of dietary services performed on a contract basis.

6. Food. Cost of raw food.

7. Nutrient Oral Feedings. Cost of nutrients in oral feedings.

D. Housekeeping expenses. (See § 6.)

1. Salaries. Gross salary of housekeeping personnel,

including housekeepers, maids and janitors.

2. Supplies. Cost of cleaners, soap, detergents, brooms and lavatory supplies.

3. Purchased Services. Cost of housekeeping services performed on a contract basis.

E. Laundry expenses.

1. Salaries. Gross salary of laundry personnel.

2. Linen. Cost of sheets, blankets and pillows.

3. Supplies. Cost of such items as soap, detergent, starch and bleach.

4. Purchased Services. Cost of other services, including commercial laundry service.

F. Maintenance and Operation of Plant. (See § 6.)

1. Salaries. Gross salary of personnel involved in operating and maintaining the physical plant, including maintenance men or plant engineer and security services.

2. Supplies. Cost of supplies used in maintaining the physical plant, including light bulbs, nails, lumber, glass.

3. Painting. Supplies and contract services.

4. Gardening. Supplies and contract services.

5. Heating. Cost of heating oil, natural gas, or coal.

6. Electricity. Self-explanatory.

7. Water, Sewer, and trash removal. Self-explanatory.

8. Purchased Services. Cost of maintaining the physical plant, fixed equipment, moveable equipment and furniture and fixtures on a contract basis.

9. Repairs and Maintenance. Supplies and contract services involved with repairing the facility's capital assets.

G. Medical records expenses.

1. Salaries-Medical Records. Gross salary of licensed medical records personnel and other department personnel.

2. Utilization Review. Fees paid to physicians attending utilization review committee meetings.

3. Supplies. All supplies used in the department.

4. Purchased Services. Medical records services

provided on a contract basis.

H. Quality Assurance Expenses.

1. Salaries. Gross salary of personnel providing quality assessment and assurance activities.

2. Purchased Services. Cost of quality assessment and assurance services provided on a contract basis.

3. Supplies. Cost of all supplies used in the department or activity.

I. Social services expenses.

1. Salaries. Salary of personnel providing medically-related social services. A facility with more than 120 beds must employ a full-time qualified social worker.

2. Purchased Services. Cost of medically-related social services provided on a contract basis.

3. Supplies. Cost of all supplies used in the department.

J. Patient activity expenses.

1. Salaries. Gross salary of personnel providing recreational programs to patients, such as arts and crafts, church services and other social activities

2. Supplies. Cost of items used in the activities program (i.e., games, art and craft supplies and puzzles).

3. Purchased Service. Cost of services provided on a contract basis.

K. Educational activities expenses.

1. Salaries. Gross salaries of training personnel.

2. Supplies. Cost of all supplies used in this activity.

3. Purchased Services. Cost of training programs provided on a contract basis.

L. Other nursing administrative costs.

1. Salaries - Other Nursing Administration. Gross salaries of ward clerks and nursing administration support staff.

2. Subscriptions. Cost of subscribing to newspapers, magazines and periodicals.

3. Office Supplies. Cost of supplies used in nursing administrative departments (e.g., pencils, papers, erasers, staples).

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4. Purchased Services. Cost of nursing administrative consultants, ward clerks, nursing administration support staff performed on a contract basis.

5. Advertising (Classified). Cost of advertising to recruit all nursing service personnel.

M. Home Office Costs. Allowable operating costs incurred by a home office which are directly assigned to the nursing facility or pooled operating costs that are allocated to the nursing facility in accordance with § 14.3 of the Nursing Home Payment System.

§ 4. Plant costs.

A. Interest.

1. Building Interest. Interest paid or accrued on notes, mortgages and other loans, the proceeds of which were used to purchase the nursing facility's real property. (See § 2.4 of the Nursing Home Payment System for Limitations)

2. Equipment Interest. Interest paid or accrued on notes, chattel mortgages and other loans, the proceeds of which were used to purchase the nursing facility's equipment. (See § 2.4 of the Nursing Home Payment System for limitations)

B. Depreciation (See § 2.12 of the Nursing Home Payment System).

1. Building Depreciation. Depreciation on the nursing facility's building.

2. Building Improvement Depreciation. Depreciation on major additions or improvements to the nursing facility (i.e., new laundry or dining room).

3. Land Improvement Depreciation. Depreciation of improvements made to the land occupied by the facility (i.e., paving, landscaping).

4. Fixed and movable equipment depreciation. Depreciation on capital equipment depreciation assets classified as fixed and moveable equipment in compliance with American Hospital Association Guidelines.

5. Leasehold Improvement Depreciation. Depreciation on major additions or improvements to building or plant where the facility is leased and the costs are incurred by the lessee (tenant).

6. Automobile Depreciation. Depreciation of those vehicles utilized solely for facility/patient services.

C. Lease/Rental.

1. Building Rental. Rental amounts paid by the provider on all rented or leased real property (land

and building).

2. Equipment Rental. Rental amounts paid by the provider on leased or rented furniture and equipment.

D. Taxes.

Property Taxes. Amount of taxes paid on the facility's property, plant and equipment.

E. Insurance.

1. Property Insurance. Cost of fire and casualty insurance on buildings and equipment.

2. Mortgage Insurance. Premiums required by the lending institution, if the lending institution is made a direct beneficiary and if premiums meet Medicare principles of reimbursement criteria for allowability.

F. Amortization-Deferred Financing Costs.

Amortization of Deferred Financing Costs (those costs directly incident to obtaining financing of allowable capital costs related to patient care services such as legal fees; guarantee fees; service fees; feasibility studies; loan points; printing and engraving costs; rating agency fees). These deferred financing costs should be capitalized and amortized over the life of the mortgage.

G. Home office capital costs.

Allowable plant costs incurred by a home office which are directly identified to the nursing facility or pooled capital costs that are allocated to the nursing facility in accordance with § 14.3 of the Nursing Home Payment System.

§ 5. Nonallowable expenses.

Nonallowable expenses include but are not limited to the following:

1. Barber and Beautician. Direct and indirect operating and capital costs related to the provision of beauty and barber services to patients.

2. Personal Items. Cost of personal items, such as cigarettes, toothpaste, and shaving cream sold to patients.

3. Vending Machines. Cost of items sold to employees and patients including candy bars and soft drinks.

4. Television/Telephones. Cost of television sets and telephones used in patient rooms.

5. Gift Shop. Direct and indirect operating and capital cost related to the provision of operating a gift shop.

6. Insurance - Officers. Cost of life insurance on

officers, owners and key employees where the provider is a direct or indirect beneficiary.

7. Income Taxes. Taxes on net income levied or expected to be levied by any governmental entity.

8. Contributions. Amounts donated to charitable or other organizations which have no direct effect on patient care.

9. Deductions from Revenue. Accounts receivable written off as bad debts, charity, courtesy or from contractual agreements are nonallowable expenses.

10. Advertising. The cost of advertisements in magazines, newspapers, trade publications, radio, and television and certain home office expenses as defined in PRM-15.

11. Cafeteria. Cost of meals to other than patients.

12. Pharmacy. Cost of all prescribed legend and nonlegend drugs.

13. Medical Supplies. Cost of medical supplies to other than patients.

14. Plant Costs. All plant costs not available for nursing facility patient care related activities are nonreimbursable plant costs.

§ 6. Nurse aide training and competency evaluation programs and competency evaluation programs (NATCEPs) costs.

A. Facility-based NATCEPs costs.

1. Salary - Staff Development. Gross salary of personnel conducting the nurse aide training and competency evaluation programs.

2. Employee Benefits. Benefits related to personnel conducting the nurse aide training and competency evaluation programs. See § 3 B for description of employee benefits.

3. Contract Services. Cost of state qualified nurse aide instructors paid on a contract basis.

4. Supplies. Cost of supplies used in conducting NATCEPs (e.g., pencils, papers, erasers, staples, textbooks and other required course materials).

5. License Fees. Cost of nurse aide registry application fees and competency evaluation testing fees paid by the NFs in behalf of the certified nurse aides.

6. Housekeeping Expenses. Housekeeping expense as defined in § 3 D for NFs which dedicate space in the facility to NATCEPs activities 100%. Housekeeping expenses shall be allocated to the NATCEPs operations

in accordance with Medicare Principles of Reimbursement.

7. Maintenance and Operation of Plant. Maintenance and operation of plant as defined in § 3 F for NFs which dedicate space in the facility to NATCEPs activities 100%. Maintenance and operation of plant expense shall be allocated to the NATCEPs operations in accordance with Medicare Principles of Reimbursement.

8. Other Direct Expenses. Any other direct costs associated with the operation of the NATCEPs. There shall be no allocation of indirect patient care operating costs as defined in § 3, except housekeeping and maintenance and operation of plant expenses.

B. Nonfacility-based NATCEPs costs.

1. Contract Services. Cost of training and competency evaluation of nurse aides paid to an outside state-approved nurse aide education program.

2. Supplies. Cost of supplies of textbooks and other required course materials provided during the nurse aide education programs by the NF.

3. License Fees. Cost of nurse aide registry application fees and competency evaluation testing fee paid by the NF on behalf of the certified nurse aides.

4. Travel. Cost for transportation provided to the nurse aides to the training or competency evaluation testing site.

§ 7.1. Criminal records background check.

Providers will be reimbursed the cost of obtaining criminal records checks from the Central Criminal Records Exchange for all persons hired for compensated employment after July 1, 1993.

NOTICE: The forms used in administering the State Plan for Medical Assistance Relating to 95% Rule; Criminal Record Checks; Blood Borne Pathogens are not being published due to the length; however, the name of each form is listed below. The forms are available for public inspection at the Department of Medical Assistance Services, 600 East Broad Street, Richmond, Virginia, or at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Room 262, Richmond, Virginia.

Hepatitis B Immunization Reporting Form

Cost Reporting Forms for Nursing Facility (Single Level of Care)

Cost Reporting Forms for Nursing Facility with Other Long Term Care Services

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Cost Reporting Forms for Nursing Facility - Nursing Facility with Multiple Level of Care or Hospital-Based Nursing Facilities

V.A.R. Doc. Nos. R94-978 and R94-979; Filed May 11, 1994, 11:46 a.m.

DEPARTMENT OF MINES, MINERALS AND ENERGY

Board of Examiners

Title of Regulation: VR 480-04-2. Board of Examiners Certification Regulations.

Statutory Authority: § 45.1-12 of the Code of Virginia.

Effective Date: June 30, 1994.

Summary:

The Board of Examiners has adopted a permanent regulation for the certification of coal and mineral miners performing specialized tasks in a mine. The regulation implements § 45.1-12 of the Code of Virginia relating to the certification of miners by the Board of Examiners. The regulation will replace the board's emergency regulation and will become effective on June 30, 1994.

The final regulation consolidates all certification standards for coal and mineral mining into one regulation. The regulation also clarifies the general administrative and examination requirements for applicants and makes them consistent for different types of certifications, wherever possible.

Several new certifications and requirements are added to address the needs of miners and the mining industry. A new coal mining certification is established for a surface facilities foreman for shops, labs, and warehouses. New mineral mining certifications are established for a mineral mining electrician, a first aid instructor, and advanced first aid.

The final regulation contains several minor changes; the requirements for the automatic elevator operator have been made more consistent with the regulations for other certifications and the requirements for the diesel engine mechanic instructor have been clarified.

Summary of Public Comment and Agency Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the office of the Registrar of Regulations.

Agency Contact: Copies of the regulation may be obtained from Stephen A. Walz, Regulatory Coordinator, Department of Mines, Minerals, and Energy, 2201 West Broad Street, Richmond, VA 23220, telephone (804) 692-3211. There may

be a charge for copies.

VR 480-04-2. Board of Examiners Certification Regulations.

PART I. GENERAL AND SPECIFIC REQUIREMENTS FOR CERTIFICATION.

§ 1.1. Administration of certification programs.

The Board of Examiners has established standards for miners seeking certification. The certification programs are administered by the Division of Mines and the Division of Mineral Mining in the Department of Mines, Minerals and Energy. Requirements for coal and mineral miners are set forth in §§ 1.2 through 1.4.

§ 1.2. General requirements for applicants.

A. Applicants shall complete and submit the Application for Certification Examination, Form BOE-1 A or BOE-1 B.

B. Applicants shall complete and submit the Certification of Work Experience Form BOE-2 A or BOE-2 B and documentation of appropriately related work experience for approval by the Division of Mines or the Division of Mineral Mining if required for the certification. This information shall be signed by a company official knowledgeable of the experience of the applicant and shall be notarized.

C. Applicants shall submit a valid standard or advanced first aid certificate or card, first responder card, Mine Safety and Health Administration Form 5000-23, or Emergency Medical Technician Certification except where noted.

D. Applicants shall submit a copy of all degrees required or evidence of successfully having completed the required training for certification.

E. Applicants shall submit a \$10 fee for each examination in the form of a cashier's check, certified check or money order. Cash will be accepted if paying in person.

F. The Application for Certification Examination and the fee shall be submitted at least five working days prior to the examination.

G. Applicants shall fulfill the requirements of this section and accumulate the required years of experience within five years of taking the examination.

H. Those applicants not meeting the requirements of subsection G of this section shall begin the application process again, submitting a new application and work experience forms, taking the examination again, and paying the fee.

§ 1.3. Examination requirements for applicants.

A. Applicants for first class mine foreman (coal), surface foreman (coal or minerals), surface foreman, open pit (minerals), underground foreman (minerals), surface blaster (coal or minerals), underground shot firer (coal), and underground blaster (minerals) certifications shall score at least 85% on each section of the written examination to pass. Applicants for all other certifications shall score at least 80% on each section of the written examination.

B. If all or part of an examination is failed and the applicant wishes to retake the test, then the applicant shall wait at least 10 working days after the initial examination before retaking the failed section or sections.

C. If a section of the examination is failed a second time, the applicant shall retake the entire examination, and shall wait at least 10 working days after the second examination before retaking the examination.

D. If the examination is failed on the third try, the applicant shall wait the greater of one year from the date of the first examination or 10 working days from the last examination to begin the examination cycle again.

E. If one year passes prior to the third take of the examination, the certification cycle shall start over with a new application, work experience forms, fee, and examination.

F. An examination may not be taken more than three times in one year.

G. Applicants for coal certifications shall also pass the gas examination unless already certified in the area or otherwise noted in the position qualifications.

§ 1.4. Requirements for reciprocity.

A. Reciprocity shall be available for persons certified by states which accept the corresponding Virginia certifications and whose certification requirements are substantially equivalent to Virginia's.

B. If reciprocity is requested by a person certified in another state which accepts the corresponding Virginia certification, a current copy of the pocket card or certificate, grades, and documentation from the other state shall be submitted in addition to fulfilling the requirements in § 1.2.

C. Applicants shall pass the examination on Virginia mining laws and regulations with a score of at least 85%.

D. Applicants shall pass any other examinations required by the Division of Mines, the Division of Mineral Mining and the Division of Mined Land Reclamation with a score of at least 85% and meet any corresponding Division of Mined Land Reclamation requirements.

PART II. CERTIFICATION REQUIREMENTS FOR COAL

MINING.

§ 2.1. First class mine foreman.

A. Applicants shall possess five years mining experience, three of which shall be underground, or appropriately related work experience approved by the Division of Mines.

B. Applicants may be given three years credit for a degree in mining engineering from an approved four-year college or two years credit for a degree in mining technology.

C. Applicants shall be at least 23 years of age.

§ 2.2. First class shaft or slope foreman.

A. Applicants shall possess five years mining work experience at a shaft or slope or appropriately related work experience approved by the Division of Mines.

B. Applicants may be given three years credit for a degree in mining engineering or two years credit for a degree in mining technology.

§ 2.3. Surface foreman.

A. Applicants shall possess five years of surface mining experience or appropriately related work experience approved by the Division of Mines.

B. Applicants may be given three years credit for a degree in mining engineering or two years credit for a degree in mining technology.

§ 2.4. Surface blaster.

A. Applicants shall possess one year blasting experience on a surface coal mine or appropriately related work experience approved by the Division of Mines.

B. Applicants shall also pass the endorsement examination required by the Division of Mined Land Reclamation and meet any corresponding Division of Mined Land Reclamation requirements.

C. Gas examination not required.

§ 2.5. Underground shot firer.

Applicants shall possess two years mining experience underground, one year of the two years shall have included handling and using explosives underground, or appropriately related work experience approved by the Division of Mines.

§ 2.6. Underground electrical repairman.

A. Applicants shall possess one year of electrical experience in underground coal mining or appropriately

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related work experience approved by the Division of Mines.

B. Applicants may be given six months credit for electrical educational training from a college, technical school, or vocational school.

§ 2.7. Surface electrical repairman.

A. Applicants shall possess one year of electrical experience in surface coal mining or appropriately related work experience approved by the Division of Mines.

B. Applicants may be given six months credit for electrical educational training from a college, technical school, or vocational school.

§ 2.8. Electrical maintenance foreman.

A. Applicants shall hold a valid electrical repairman certification prior to being eligible to take the electrical maintenance foreman examination.

B. Applicants shall possess three years electrical experience as applied to underground mining or appropriately related work experience approved by the Division of Mines.

C. Applicants may be given one year credit for an electrical engineering degree, or six months credit for electrical education training from a technical or vocational school.

D. Gas examination not required.

§ 2.9. Chief electrician.

A. Applicants shall hold a valid maintenance foreman certification prior to being eligible to take the chief electrician examination.

B. Applicants shall possess five years electrical experience as applied to underground mining or appropriately related work experience approved by the Division of Mines.

C. Applicants may be given two years credit for an electrical engineering degree, or six months credit for electrical educational training from a technical or vocational school.

D. Gas examination not required.

§ 2.10. Hoisting engineer.

A. Applicants shall possess two years of practical mining experience and one year of hoisting experience or appropriately related work experience approved by the Division of Mines. A certified hoisting engineer shall verify the hoisting experience.

B. After the examination has been successfully completed, the applicant shall obtain written permission from a mine official to have a representative from the Division of Mines observe the applicant's operation of hoisting equipment at the mine. Permission shall be on company stationery, signed by the company official, and submitted to the Division of Mines.

§ 2.11. Top person.

Applicants shall possess one year of practical mining experience with at least 30 days under the direction of a certified top person or appropriately related work experience approved by the Division of Mines.

§ 2.12. Preparation plant foreman.

A. Applicants shall possess five years experience, at least one year shall be at a preparation plant, or appropriately related work experience approved by the Division of Mines.

B. Applicants may be given three years credit for a degree in mining engineering or two years credit for a degree in mining technology.

§ 2.13. Dock foreman.

Applicants shall possess two years experience at a dock or appropriately related work experience approved by the Division of Mines.

§ 2.14. Mine inspector.

A. Applicants shall possess seven years underground mining experience.

B. Applicants may be given three years credit for a degree in mining engineering.

C. Applicants shall hold a valid First Class Mine Foreman Certification.

D. Gas examination not required.

E. A certificate will not be issued until an applicant is employed by the Department of Mines, Minerals and Energy.

§ 2.15. Underground diesel engine mechanic.

A. All maintenance work performed on diesel engines used to power equipment in underground coal mines must be performed by, or under the direct supervision of, a person possessing a Diesel Engine Mechanic Certificate issued by the Board of Examiners. In addition, no operator of an underground coal mine in the Commonwealth of Virginia may use diesel-powered equipment in the [a] mine without first employing a diesel engine mechanic who is certified by the Board of Examiners.

B. "Maintenance" means all of the tasks required to be performed routinely to ensure that the engine exhaust emissions conform with the requirements of the laws and regulations of Virginia, and with the maintenance recommendations of the manufacturer of the engine.

C. Applicants shall possess six months experience as a diesel engine mechanic, complete a diesel engine mechanic course approved by the Division of Mines, or possess appropriately related work experience approved by the Division of Mines. A one-year diesel engine mechanic program approved by the Division of Mines may be substituted for the diesel engine mechanic experience.

D. The initial training course for diesel engine mechanics shall include at least 32 hours of classroom instruction and be taught by instructors certified by the Division of Mines.

E. To qualify for consideration and approval by the Chief, the content of the initial training course for diesel engine mechanics shall include, but not be limited to:

1. Diesel engine principles;
2. Diesel fuel and fuel systems;
3. Engine exhaust systems;
4. Diesel laws and regulations;
5. Safe use of equipment;
6. Emission controls and testing; and
7. Protection of health of workers exposed to diesel equipment.

F. The annual retraining course for diesel engine mechanics shall include at least four hours of classroom instruction and be taught by instructors certified by the Division of Mines.

G. The content of the retraining course shall include, but not be limited to:

1. Diesel technology;
2. Diesel laws and regulations;
3. Safe use of equipment; and
4. Protection of health of workers exposed to diesel equipment.

H. Gas examination not required.

I. A Diesel Engine Mechanic Certificate shall remain valid until December 31 following the anniversary date of the training, providing the certification requirements are met, unless the certificate is revoked by the Board of

Examiners.

J. The holder of the certificate shall renew the certificate by satisfactorily completing a diesel engine mechanic retraining course approved by the Division of Mines and taught by an instructor approved by the Division of Mines.

K. The holder of the certificate shall submit documentation to the Division of Mines indicating the required retraining has been completed before the expiration of the card.

L. If a certificate expires because the certificate holder fails to complete the retraining requirements, then the holder of the expired certificate shall complete the retraining requirements and pass the Diesel Engine Mechanic Examination prior to the reinstatement of certification, unless otherwise approved by the Chairman of the Board of Examiners.

§ 2.16. Diesel engine mechanic instructor.

A. Applicants shall have teaching experience and be a certified diesel mechanic or possess appropriately related work experience approved by the Division of Mines.

B. Gas examination not required.

C. Applicants shall maintain the certificate by teaching at least one approved diesel engine mechanic course every two years or at least one approved diesel engine mechanic retraining course every year.

D. The holder of the certificate shall submit documentation to the Division of Mines indicating the required teaching has been completed before the expiration of the card.

E. The Board of Examiners may revoke the certification, in accordance with § 45.1-13 of the Code of Virginia, when the certificate holder fails to meet these validation requirements.

F. If a certificate expires because the certificate holder fails to complete the [~~retraining~~ teaching] requirements, then the holder of the expired certificate shall [~~complete the retraining requirements and~~] pass the Diesel Engine Mechanic Instructor Examination prior to the reinstatement of certification.

§ 2.17. Advanced first aid.

A. Applicants shall complete a 40-hour advanced first aid class taught by an approved advanced first aid instructor or possess appropriately related work experience approved by the Division of Mines.

B. Approved advanced first aid classes shall cover the following subjects:

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1. Introduction to first aid;
2. Respiratory emergencies and artificial respiration;
3. Removal of foreign bodies from the throat (the Heimlich Maneuver) and cardiopulmonary resuscitation (CPR);
4. Wounds;
5. Shock;
6. Specific injuries including head and chest;
7. Contamination, infection, and prevention;
8. Burns;
9. Cold exposure and frost bite;
10. Bone and joint injuries;
11. Dressings and bandages;
12. Sudden illness;
13. Emergency rescue and transfer;
14. Unusual rescue situations;
15. Poisoning;
16. Transportation of victims; and
17. Heat exposure.

C. Certified persons shall complete eight hours training biannually by an advanced first aid instructor approved by the Division of Mines to maintain their advanced first aid card.

D. The holder of the certificate shall submit documentation to the Division of Mines indicating the required training has been completed before the expiration of the card.

§ 2.18. First aid instructor.

A. Applicants shall be certified as a first aid instructor by the American Red Cross or other certified instructor approved by the Division of Mines.

B. The first aid instructor card shall be good for two years.

C. The holder of the certificate shall submit documentation to the Division of Mines indicating that they have continued their certification as required by subsection A of this section before the expiration of the card.

§ 2.19. Surface facilities foreman for shops, labs and warehouses.

A. Applicants shall possess one year work experience at a shop, lab or warehouse or appropriately related work experience approved by the Division of Mines.

B. This certification shall not be used in lieu of the surface foreman, prep plant foreman or dock foreman certifications.

§ 2.20. Automatic elevator operator.

A. Applicants shall possess one year actual mining experience working in and around a mine [or appropriately related work experience approved by the Division of Mines] .

B. The applicant shall obtain written permission from a mine official to have a representative from the Division of Mines observe the applicant's operation of an automatic elevator at the mine. Permission shall be presented on company stationery, signed by the company official, and submitted to the Division of Mines prior to the visit. The applicant shall demonstrate proper use of the equipment.

§ 2.21. Gas detection qualification for coal mining.

A. The applicant shall demonstrate the proper use of equipment at the time of the examination or at the mine.

B. No general requirements shall apply.

PART III. CERTIFICATION REQUIREMENTS FOR MINERAL MINING.

§ 3.1. Underground foreman.

A. Applicants shall possess five years mining experience at an underground mineral mine or appropriately related work experience approved by the Division of Mineral Mining.

B. Applicants may be given three years credit for a degree in mining engineering or civil engineering or two years credit for a degree in mining technology or civil technology.

C. Applicants shall possess a valid first aid certificate which represents completion of a first aid course with a minimum of eight hours training.

§ 3.2. Surface foreman.

A. Applicants shall possess five years mining experience, at least one year at a surface mineral mine, or appropriately related work experience approved by the Division of Mineral Mining.

B. Applicants may be given three years credit for a

degree in mining engineering or civil engineering or two years credit for a degree in mining technology or civil technology.

C. Applicants shall possess a valid first aid certificate which represents completion of a first aid course with a minimum of eight hours training.

§ 3.3. *Surface foreman, open pit (not applicable to mines with on-site blasting).*

A. Applicants shall possess five years mining experience, with at least one year at a surface mineral mine or appropriately related work experience approved by the Division of Mineral Mining.

B. Applicants may be given three years credit for a degree in mining engineering or civil engineering or two years credit for a degree in mining technology or civil technology.

C. Applicants shall possess a valid first aid certificate which represents completion of a first aid course with a minimum of eight hours training.

§ 3.4. *Surface blaster.*

Applicants shall possess one year blasting experience on a surface mineral mine under the supervision of a certified blaster or possess appropriately related work experience approved by the Division of Mineral Mining.

§ 3.5. *Underground blaster.*

Applicants shall possess two years of work experience in an underground mine with at least one year handling and using explosives underground or possess appropriately related work experience approved by the Division of Mineral Mining.

§ 3.6. *Mineral mining electrician.*

A. Applicants shall hold a valid journeyman electrical certification issued under Department of Housing and Community Development criteria or possess appropriately related work experience approved by the Division of Mineral Mining.

B. Applicants shall complete training as required by 30 CFR Part 48 and submit documentation of such training to the Division of Mineral Mining.

C. Employees of licensed electrical contractors having completed hazard training under 30 CFR Part 48 shall be allowed to complete electrical work at the mine.

§ 3.7. *Advanced first aid.*

A. Applicants shall complete a 40-hour advanced first aid class taught by an approved advanced first aid instructor or possess appropriately related work

experience approved by the Division of Mineral Mining.

B. Subjects which shall be covered in the advanced first aid class are listed in § 2.17 of this regulation.

§ 3.8. *First aid instructor.*

Applicants shall be certified as a first aid instructor by the American Red Cross or other certified instructor as approved by the Division of Mineral Mining.

VA.R. Doc. No. R94-991; Filed May 11, 1994, 10:05 a.m.

APPLICATION FOR CERTIFICATION EXAMINATION
COAL MINING

Board of Examiners

Applicants for certification must complete an application and submit a \$10.00 fee for each exam to be taken. Type or print the application in ink and pay the fee with a certified check, cashier's check, or money order made payable to the TREASURER OF VIRGINIA. Cash will be accepted if paid in person. Submit the application and fee to the Board of Examiners, P.O. Drawer 900, Big Stone Gap, VA 24219 at least FIVE WORKING DAYS prior to the date of examination.

1. Full Name _____ S.S.# _____
2. Address _____
street or P.O. Box _____ city _____ state _____ zip code _____
3. Date of Birth _____ month/day/year _____ Home Phone No. (____) _____
4. Total years employed at a coal mine: _____
underground _____ surface _____
5. List your current (or most recent) mining experience:
Company Name _____
Address _____
street or P.O. Box _____ city _____ state _____ zip code _____
Job Title _____ From _____ month/day/year _____ To _____ month/day/year _____
6. Attach copies of the required documentation needed for each certification.
7. Examination Requested (Circle One): first class mine foreman, first class shaft or slope foreman, surface foreman, surface blaster, underground shot firer, underground electrical repairman, surface electrical repairman, electrical maintenance foreman, chief electrician, hoisting engineer, top person, preparation plant foreman, dock foreman, mine inspector, underground diesel engine mechanic, diesel engine instructor, advanced first aid, first aid instructor, surface facilities foreman for shops, labs and warehouses, automatic elevator operator, gas detection qualification, other: _____

I HEREBY CERTIFY THAT THE ABOVE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signed _____ Date _____

30E-1 A
Rev 1/9/74

HAVE TEN CITIZENS OF YOUR COMMUNITY SIGN THE FOLLOWING STATEMENT:

I HEREBY CERTIFY that I am personally acquainted with that above named applicant and know him as a man of good moral character and temperate habit.

	NAME	ADDRESS	TITLE OR POSITION
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

CERTIFICATE OF WORK EXPERIENCE FORM COAL MINING

Board of Examiners

All applicants for certification must complete a form for each employer to verify the required years of mining experience for the certificate requested. Applicants must have the form signed by a company official knowledgeable of his or her work history before a notary public. Type or print the information in ink and submit the form to the Board of Examiners, U.S. Route 23 South, Drawer 900, Big Stone Gap, VA 24219.

1. Full Name _____ S.S.# _____
2. Address _____ street or P.O. Box _____ city _____ state _____ zip code _____
3. Employer/Company Name _____ Mine Name _____
Address _____ street or P.O. Box _____ city _____ state _____ zip code _____
4. Job Title _____ From _____ month/day/year _____ To _____ month/day/year _____

Description of job duties applicable to certification requested: _____

5. I hereby certify, under the penalties of perjury, that the information related to this applicant's experience as submitted on this form is correct.

Signature of company official _____ print or type name _____ title _____ date _____
 5. State of _____ county/city of _____ to wit: _____
 I, _____, a notary public in and for the State and _____ whose name is _____ company official _____
 signed to /s/ above, on the _____ day of _____, 19____ has acknowledged the same before me in my county/city aforesaid. Given under my hand this day of _____, 19____ notary public _____
 My commission expires the _____ day of _____, 19____

30E-2A
REV 2/10/94

SEAL

APPLICATION FOR CERTIFICATION EXAMINATION MINERAL MINING

Board of Examiners

Applicants for certification must complete an application and submit a \$10.00 fee for each exam to be taken. Type or print the application in ink and pay the fee with a certified check, cashier's check, or money order made payable to the TREASURER OF VIRGINIA. Cash will be accepted if paid in person. Submit the application and fee to the Board of Examiners, 7705 Timberlake Road, P.O. Box 4499, Lynchburg, VA 24502 at least FIVE WORKING DAYS prior to the date of examination (Note: The office is scheduled to relocate in Charlottesville in Fall 1994).

1. Full Name _____ S.S.# _____
 2. Address _____ street or P.O. Box _____ city _____ state _____ zip code _____
 3. Date of Birth _____ month/day/year _____ Home Phone No. () _____
 4. Total years employed at a mineral mine: _____ underground _____ surface _____
 5. List your current (or most recent) mining experience: _____
- Company Name _____
 Address _____ street or P.O. Box _____ city _____ state _____ zip code _____
 Job Title _____ From _____ month/day/year _____ To _____ month/day/year _____

5. Attach documentation of any training or education completed which is required for certification:
 - a. Valid first aid certificate required for underground foreman, surface foreman, and surface foreman-open pit.
 - b. Valid standard or advanced first aid certificate/card, first responder card, MSHA form 5000-23, or EMF certification required for surface and underground blaster.
 - c. Valid advanced first aid card or certificate and first aid instructor certificate for the advanced first aid and first aid instructor certifications, respectively.
 - d. Valid copy of pocket card or certificate, grades and documentation required for those requesting reciprocity from another state.
 - e. Copy of degree for foreman certification, if applicable.
7. Examination Requested (circle one): underground foreman, surface foreman, surface foreman - open pit, surface blaster, underground blaster, advanced first aid, or other: _____

I HEREBY CERTIFY THAT THE ABOVE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signed _____ Date _____

30E-1 B
REV 2/3/94

CERTIFICATE OF WORK EXPERIENCE FORM
MINERAL MINING

Board of Examiners

All applicants for certification must complete a form for each employer to verify the required years of mining experience for the certificate requested. Applicants must have the form signed by a company official knowledgeable of his or her work history before a notary public. Type or print the information in ink and mail the form to the Board of Examiners, P.O. Box 4499, Lynchburg, VA 24502.

HAVE TEN CITIZENS OF YOUR COMMUNITY SIGN THE FOLLOWING STATEMENT.

I HEREBY CERTIFY that I am personally acquainted with that above named applicant and know him as a man of good moral character and temperate habit.

	NAME	ADDRESS	TITLE OR POSITION
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

1. Full Name _____ S.S.# _____
 2. Address _____
 street or P.O. Box city state zip code
 3. Employer/Company Name _____ Mine Name _____
 Address _____
 street or P.O. Box city state zip code
 4. Job Title _____ From _____ To _____
 month/day/year month/day/year
 Description of job duties applicable to certification requested: _____

5. I hereby certify, under the penalties of perjury, that the information related to this applicant's experience as submitted on this form is correct.

signature of company official print or type name title date

6. State of _____ county/city of _____ to wit:

I, _____, a notary public in and for the State and
 county/city aforesaid, do certify that _____ whose name is
 company official
 signed to #5 above, on the _____ day of _____, 19____ has acknowledged the
 same before me in my county/city aforesaid. Given under my hand this _____
 day of _____, 19____
 notary public
 My commission expires the _____ day of _____, 19____

30E-2B
Rev 2/10/94

SEAL

VIRGINIA WASTE MANAGEMENT BOARD

Title of Regulation: VR 672-40-01. Infectious Waste Management Regulations (REPEALED).

Title of Regulation: VR 672-40-01:1. Regulated Medical Waste Management Regulations.

Statutory Authority: Chapter 14 (§ 10.1-1400 et seq.) of Title 10.1 of the Code of Virginia.

Effective Date: June 29, 1994.

Summary:

The regulations are constructed in 11 parts. In Part I, the definitions used in the succeeding parts are listed. The statutes and solid waste regulations are cited as supplementing these regulations. Part II states the purpose and authority for the regulations. The relationship to other state and local rules is established. Where there is no mutually exclusive conflict, both regulated medical waste management regulations and the other rules must be obeyed.

Part III is devoted to defining regulated medical waste. A general, descriptive definition of regulated medical waste is combined with a specific list of controlled regulated medical wastes. A list is included of activities that are exempted from all or part of the regulations. A list is included of solid wastes that are specifically excluded from consideration as regulated medical wastes, and a list is included of wastes that are regulated medical wastes but are specifically excluded from requirements of the regulations.

Permits for storage, treatment and disposal of regulated medical wastes are required in Part IV. Qualifying on-site facilities may be considered to have a permit (by rule), without formal application procedures, after their operators make a notification to the director of their identity and conformance to statutory requirements for local government certification and disclosure by key personnel. Detailed rules for packaging the waste are listed. For waste to be transported, additional rules describe boxing and labeling standards. Minimum standards for spill management, reusable container management, financial assurance, record keeping and closure are established. Regulated medical waste must be treated by one of five treatment processes, treated by an approved innovative technology, or disposed of in a sanitary sewer system.

Part V describes requirements for storage facilities, including refrigeration for periods beginning seven days after the date of generation. Part VI describes requirements for transportation. Transporters, other than the U. S. Postal Service, are required to register with the department and to placard vehicles.

Part VII contains operational standards for incineration facilities. Part VIII contains operational standards for steam sterilization facilities. Part IX contains operational standards for alternative treatment facilities.

Part X sets out the procedures for acquiring and holding a permit to store, treat or dispose of regulated medical waste. Ten years is the maximum permit life; however, a renewal process is defined. Existing facilities are relieved of meeting conflicting new standards for six months. Part XI provides procedures for acquiring and holding a special variance from the regulations and for approval of innovative treatment technologies.

Changes to the proposed regulations incorporated in the final regulations are as follows:

Part I

- 1. The new term, "Regulated Medical Waste Management Facility," is added for clarity.*
- 2. The term, "Pathological waste," is deleted, and all further uses are deleted. The term is ambiguous and can be replaced by more specific language.*

Part II

- 3. At § 2.4 B, the last sentence is deleted and replaced. This change allows all parties one year to come into compliance with items in these regulations that were not a part of the emergency regulations.*

Part III

- 4. Some commenters seemed confused as to how Part III sections worked together. New text attempts to explain the functioning of the chapter at its outset.*
- 5. The requirement that all treated waste be relabeled to identify it is deleted. New text forbids the packaging of non-regulated waste as regulated waste.*
- 6. At § 3.5 5, new text explains how the two subsections work together.*
- 7. Microbiological laboratory managers are allowed the same exemption available to health care professionals. They are not health professionals by definition of licensing agencies, but they do have advanced training and responsibility.*
- 8. "Limited" is substituted for "required" for clarity.*
- 9. "§ 4.17" is deleted and sections are renumbered.*
- 10. At § 3.6, new text explains how the three subsections work together.*

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11. At § 3.3 C 2, a comma is replaced with the phrase, "generated at." This makes the complex statement clearer. Another comma is added to help.

12. At § 3.8 3, the term "pathological waste" is deleted, as it is in all the regulations. The meaning of the term is ambiguous and used in conflicting ways in society. The intent of the section is made clearer by substituting a more direct description or list of the materials that are intended.

Part IV

13. Additional text exempts storage at loading docks and in bulk containers if such storage consists primarily of waste generated on-site and involves transportation related holding for less than seven days. The term, "a permit by rule," in Part IV is changed here and elsewhere to "an on-site permit by rule" to differentiate it from the newly established "off-site permit by rule" in Part X.

14. The current ASTM standard, "Standard Test Method for Drop Test of Loaded Containers by Free Fall, D5276-92" is substituted for the dated standard previously cited in the section.

15. At § 4.6 B 4, the unique Virginia standard is deleted leaving the USDOT performance based standard. Commenters felt the Virginia standard was too stringent and interfered with interstate commerce.

16. At § 4.10, a reference to U.S. Centers for Disease Control guidelines for worker clothing is deleted. A commenter noted that the reference is dated and suggested a new reference; however, the Occupational Safety and Health Administration has moved strongly into the health care field, and a requirement that a federal guideline be complied with is now unnecessary and inappropriate.

17. At § 4.11 1, the second sentence is redrafted for clarity.

18. At § 4.11 3, simple mechanical mechanisms are indicated as a means of compliance. Commenters felt they might be overlooked as a solution in favor of complicated and expensive devices. In practice, simpler may be better.

19. At § 4.15 A, "or" is added for clarity.

20. At § 4.15 C, the section is deleted and the next section is renumbered. Commenters pointed out a difficulty in determining compliance with the section and that the requirement was inappropriate for certain types of treatment. The requirement was rooted in a historical view of treatment and has been overcome by progress in treatment techniques.

21. At § 4.15 D (renumbered § 4.15 C), text is added

to require all grinding, shredding and puncturing be done in a safe and sanitary manner. Some commenters suggested more detailed requirements. This general mandate for inspectors and OSHA regulations should be sufficient.

22. At § 4.16 A 1, "ad hoc" is deleted as it is not needed.

23. At § 4.18, the section is deleted. Commenters felt small facilities should not make the reports and others felt the report was unfair to larger generators.

Part V

24. At § 5.5, a new second sentence replaces a requirement for cover over and catchment under places where waste is transferred. The new language attempts to exclude transient operations such as pickups at private offices and to only include continuing operations.

25. At § 5.6 3, simple mechanical mechanisms are indicated as means of compliance. Commenters felt they might be overlooked as a solution in favor of complicated and expensive devices. In practice, simpler may be better.

Part VI

26. At § 6.5, a new second sentence replaces a requirement for cover over and catchment under places where waste is transferred. The new language attempts to exclude transient operations such as pickups at private offices and to only include continuing operations.

27. At § 6.6 C, a requirement for placarding of vehicles is deleted. The change removes a possible conflict with hazardous materials transport regulations and leaves the matter to those regulations.

Part VII

28. At § 7.3 D, the term "untested material" is substituted for "ash," and new text is inserted to allow mixing of ash and dusts after they are determined to not be hazardous waste.

29. Radiation monitoring in § 7.6 is deleted, and the section is reserved in order to further study and consider the issues and implications.

Part VIII

30. At § 8.2 2 d, substituted text increased the "approximate" size of the shredded or ground material to 0.75 inches instead of a precisely defined 0.50 inches. Commenters felt the proposed specification was severe and perhaps unachievable.

31. At § 8.2 2 d, a new requirement substitutes forced draft ventilation control for closed conveyance between treatment units. While some commenters were concerned with vapor emissions into the work area, others felt fully enclosed units were not available. The substituted text attempts to address both concerns. A reordering and correction of cross references is also included.

32. A new section, § 8.2 2 e, requires control of emissions from shredding and grinding operations. This was neglected in Part VIII, but it was contained in Part IX. The error is corrected. A second sentence makes clear that emissions that have themselves been sterilized do not require further filtration.

33. At § 8.3 B, "or" is substituted for "and" to allow flexibility. The term "shredded or ground" is added as a modifier for solid waste to clarify which solid waste is intended.

34. At § 8.3 C, the general requirement that all treated waste be relabeled to identify it is deleted and new text clarifies the intent of other subsections.

35. At § 8.3 E steam sterilization facilities in operation before July, 1994, or under one hundred pounds per day in rate of treatment are not required to shred or grind the waste. Instead, they repackage and label the waste as having been treated. Commenters felt grinding or shredding might be impractical for small facilities and existing facilities. The change makes the process optional but preserves a mechanism by which disposers can recognize treated waste from untreated waste.

36. Radiation monitoring in § 8.5 is deleted, and the section is reserved in order to further study and consider the issues and implications.

Part IX

37. At § 9.2 1 a, substituted text increased the "approximate" size of the shredded or ground material to 0.75 inches instead of a precisely defined 0.50 inches. Commenters felt the proposed specification was severe and perhaps unachievable. Also at § 9.2 1 a, a new requirement substitutes forced draft ventilation control for closed conveyance between treatment units. While some commenters were concerned with vapor emissions into the work area, others felt fully enclosed units were not available. The substituted text attempts to address both concerns. Also, a cross reference is corrected to agree with changes later in the part. Reordering of numerical references is included to improve the readability of the section.

38. At § 9.2 1 b, a cross reference to testing protocols is added.

39. At § 9.2 1 d, a cross reference to a related exception to the rule is added. Also, a requirement is added that the operation be carried out in a safe and sanitary manner.

40. At § 9.2 2, new text requires grinding or shredding precede rather than follow treatment. This is the case in the prescribed treatment methods as they are known. Alternates should be evaluated under procedures of Part XI.

41. At § 9.2 2 c (2), new text allows substitution of interval sampling for continuous. A major vendor of such equipment indicated that continuous sampling equipment is not economically available in all size ranges.

42. The entire text of § 9.3 C is deleted and subsequent sections renumbered. This action coordinates with other deletions of requirements for labelling all treated wastes.

43. Radiation monitoring in § 9.5 is deleted, and the section is reserved in order to further study and consider the issues and implications.

Part X

44. Text at § 10.2 D is moved to § 10.2 A as a second sentence. A clarifying clause is added to the first sentence to tell what part of the regulations is meant.

45. A new § 10.2 D includes a new "off-site permit by rule" procedure which allows off-site facilities a less complicated and quicker process for becoming permitted. The section contains essentially the same procedures and requirements as those for solid waste transfer stations and incinerators under the Solid Waste Management Regulations. The details procedures and requirements are explained within § 10.2 D.

46. In Appendix 10.4, item D 2 is deleted and subsequent sections renumbered. The item relates to landfills and is inappropriate.

Forms

47. In the forms, pages 3 and 8, references to pathological wastes are replaced by a more direct description of the materials.

Summary of Public Comment and Agency Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the office of the Registrar of Regulations.

Agency Contact: Copies of the regulation may be obtained from Cindy M. Berndt, Regulatory Coordinator, Department

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of Environmental Quality, 629 East Main Street, Richmond, VA 23219, telephone (804) 762-4378. There may be a charge for copies.

VR 672-40-01.1. Regulated Medical Waste Management Regulations.

PART I. DEFINITIONS.

§ 1.1. Definitions.

The following words and terms, when used in these regulations, shall have the following meanings unless the context clearly indicates otherwise. Chapter 14 (§ 10.1-1400 et seq.) of Title 10.1 of the Code of Virginia defines words and terms that supplement those in these regulations. The Virginia Solid Waste Management Regulations, VR 672-20-10, define additional words and terms that supplement those in the statutes and these regulations. When the statutes, as cited, and the solid waste management regulations, as cited, define a word or term differently, the definitions of the statutes are controlling.

"Act" or "regulations" means the federal or state law or regulation last cited in the context, unless otherwise indicated.

"Alternative treatment method" means a method for the treatment of regulated medical waste that is not incineration or steam sterilization (autoclaving).

"Approved sanitary sewer system" means a network of sewers serving a facility that has been approved in writing by the Virginia Department of Health, including affiliated local health departments. Such sewer systems may be approved septic tank/drainfield systems and on-site treatment systems, or they may be a part of a collection system served by a NPDES permitted treatment works.

"Associated" means two or more firms that share staff members, management, directors, assets or engage in joint ventures. Holding companies and part owners are associated parties.

"Ash" means the residual waste material produced from an incineration process or any combustion.

"ASTM" means the American Society For Testing and Materials.

"Autoclave tape" means tape that changes color or becomes striped when subjected to temperatures that will provide sterilization of materials during treatment in an autoclave or similar device.

"Board" means the Virginia Waste Management Board.

"Body fluids" means any liquid emanating or derived

from humans or animals and not limited to blood; cerebrospinal, synovial, pleural, peritoneal and pericardial fluids; and semen and vaginal secretions.

"Closure" means the act of securing a regulated medical waste management facility pursuant to the requirements of these regulations.

"Closure plan" means the plan for closure prepared in accordance with the requirements of these regulations.

"Commonwealth" means the Commonwealth of Virginia.

"Conflict" means that provisions of two documents, such as regulations or a permit, do not agree and both provisions cannot be complied with simultaneously. If it is possible for both provisions to be complied with, no conflict exists.

"Container" means any portable enclosure in which a material is stored, transported, treated, disposed of, or otherwise handled.

"Contamination" means the degradation of naturally occurring water, air, or soil quality either directly or indirectly as a result of human activity; or the transfer of disease organisms, blood or other matter that may contain disease organisms from one material or object to another.

"Contingency plan" means a document setting out an organized, planned and coordinated course of action to be followed in the event of a fire, explosion, or release of regulated medical waste or regulated medical waste constituents that could threaten human health or the environment.

"CWA" means the Clean Water Act (formerly referred to as the Federal Water Pollution Control Act), 33 USC 1251 et seq.; PL 92-500, PL 93-207, PL 93-243, PL 93-592, PL 94-238, PL 94-273, PL 94-558, PL 95-217, PL 95-576, PL 96-148, PL 96-478, 96-483, PL 96-510, PL 96-561, PL 97-35, PL 97-117, PL 97-164, PL 97-216, PL 97-272, PL 97-440, PL 98-45, PL 100-4, PL 100-202, PL 100-404, and PL 100-668.

"Department" means the Virginia Department of Environmental Quality.

"Director" means the Director of the Department of Environmental Quality.

"Discharge" or "waste discharge" means the accidental or intentional spilling, leaking, pumping, pouring, emitting, emptying, or dumping of regulated medical waste into or on any land or state waters.

"Disposal" means the discharge, deposit, injection, dumping, spilling, leaking, or placing of any regulated medical waste into or on any land or water so that such regulated medical waste or any constituent thereof may enter the environment or be emitted into the air or discharged into any waters, including ground waters.

"Disposal facility" means a facility or part of a facility at which regulated medical waste is intentionally placed into or on any land or water, and at which the regulated medical waste will remain after closure.

"Domestic sewage" means untreated sanitary wastes that pass through a sewer system.

"EPA" means the U.S. Environmental Protection Agency.

"Etiologic agents" means organisms defined to be etiologic agents in Title 49 of the U. S. Code of Federal Regulations at § 173.134.

"Federal agency" means any department, agency, or other instrumentality of the federal government, any independent agency, or establishment of the federal government including any government corporation and the Government Printing Office.

"Generator" means any person, by site location, whose act or process produces regulated medical waste identified or listed in Part III of these regulations or whose act first causes a regulated medical waste to become subject to these regulations.

"Hazardous material" means a substance or material that has been determined by the United States Secretary of Transportation to be capable of posing an unreasonable risk to health, safety, and property when transported in commerce and that has been so designated under 49 CFR 171 and 173.

"Hazardous waste" means any solid waste defined as a "hazardous waste" by the Virginia Hazardous Waste Management Regulations.

"Highly leak resistant" means that leaks will not occur in the container even if the container receives severe abuse and stress, but remains substantially intact.

"Highly puncture resistant" means that punctures will not penetrate the container even if the container receives severe abuse and stress, but remains substantially intact.

"Limited small clinic" means an office where fewer than 10 health care professionals practice, no surgical procedures are performed, and is under the total administrative control of one or more of those practitioners. A person practicing under a license issued by the Department of Health Professions is a health care professional.

"Motor vehicle" means a vehicle, machine, roll off container, tractor, trailer, or semi-trailer, or any combination thereof, propelled or drawn by mechanical power and used in transportation or designed for such use.

"Nonstationary health care providers" means those

persons who routinely provide health care at locations that change each day or frequently. This term includes traveling doctors, nurses, midwives, and others providing care in patients' homes, first aid providers operating from emergency vehicles, and mobile blood service collection stations.

"NPDES" or "National Pollutant Discharge Elimination System" means the national program for issuing, modifying, revoking, reissuing, terminating, monitoring, and enforcing permits pursuant to §§ 307, 402, 318, and 405 of CWA. The term includes any state or interstate program that has been approved by the Administrator of the United State Environmental Protection Agency.

"Off-site" means any site that does not meet the definition of on-site as defined in this part.

"On-site" means the same or geographically contiguous property, which may be divided by public or private right-of-way, provided the entrance and exit between the properties is at a cross-roads intersection, and access is by crossing as opposed to going along, the right-of-way. Noncontiguous properties owned by the same person but connected by a right-of-way that he controls and to which the public does not have access, is also considered on-site property.

"Owner" means the person who owns a regulated medical waste management facility or part of a regulated medical waste management facility.

"Package" or "outside package" means a package plus its contents.

"Packaging" means the assembly of one or more containers and any other components necessary to assure compliance with minimum packaging requirements under VRGTHM or these regulations.

["Pathological waste" means a solid waste that is human tissues, organs, body parts, fetuses, placentas, body fluids or similar material; or is animal tissue, organs, body parts, fetuses, placentas, body fluids or similar material from animals, if the animal was exposed to human pathogens for the purposes of testing or experimentation.]

"Permit by rule" means provisions of these regulations stating that a facility or activity is deemed to have a permit if it meets the requirements of the provision.

"Permitted waste management facility" or "permitted facility" means a regulated medical waste treatment, storage, or disposal facility that has received a permit in accordance with the requirements of the regulations.

"Physical construction" means excavation, movement of earth, erection of forms or structures, the purchase of equipment, or any other activity involving the actual preparation of the regulated medical waste management

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facility.

"Principal corporate officer" means either:

1. A president, secretary, treasurer, or vice president of the corporation in charge of a principal business function, or any other person who performs similar policy, or decision making function for the corporation, or

2. The manager of one or more manufacturing, production, or operating facilities employing more than 250 persons or having gross annual sales or expenditures exceeding \$25 million (in second-quarter 1980 dollars), if authority to sign documents has been assigned or delegated to the manager in accordance with corporate procedures.

"Principal executive officer" means either:

1. For a federal agency:

- a. The chief executive officer of the agency; or
- b. A senior executive officer having responsibility for the overall operations of a principal geographic unit of the agency (e.g., Regional Administrators of EPA).

2. For a state agency: The chief executive officer of a department, board, commission, hospital, educational institution, or an authority.

3. For a municipality: The chief executive officer of a county, city, or town.

"Processing" means preparation, treatment, or conversion of regulated medical waste by a series of actions, changes, or functions that bring about a decided result.

"Publicly owned treatment works" or "POTW" means any device or system used in the treatment (including recycling and reclamation) of municipal sewage or industrial wastes of a liquid nature that is owned by a state or municipality (as defined by § 502(4) of the CWA).

"Putrescible waste" means regulated medical waste that contains material capable of being decomposed by microorganisms.

"RCRA" means the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act (42 USC 6901 et seq.).

"Regulated medical waste" means solid wastes defined to be regulated medical wastes in Part III of these regulations.

"Regulated medical waste management" means the systematic administration of activities that provide for the

collection, source separation, storage, transportation, transfer, processing, treatment, and disposal of regulated medical wastes whether or not such facility is associated with facilities generating such wastes or otherwise.

["Regulated medical waste management facility" means a solid waste management facility that manages regulated medical waste.]

"Sanitary sewer system" means a system for the collection and transport of sewage, the construction of which was approved by the Department of Health or other appropriate authority.

"Secondary container" means a storage device into which a container can be placed for the purpose of containing any leakage from the original container.

"Section" means a subpart of these regulations and when referred to all portions of that part apply.

"Sharps" means needles, scalpels, knives, glass, syringes, pasteur pipettes and similar items having a point or sharp edge or that are likely to break during transportation and result in a point or sharp edge.

"Shipment" means the movement or quantity conveyed by a transporter of a regulated medical waste between a generator and a designated facility or a subsequent transporter.

"Site" means the land or water area upon which a facility or activity is physically located or conducted, including but not limited to adjacent land used for utility systems such as repair, storage, shipping, or processing areas, or other areas incident to the controlled facility or activity.

"Solid waste" means any garbage, refuse, sludge and other discarded material, including solid, liquid, semisolid or contained gaseous material, resulting from industrial, commercial, mining and agriculture operations, or community activities, but does not include (i) solid or dissolved material in domestic sewage, (ii) solid or dissolved material in irrigation return flows or in industrial discharges which are sources subject to a permit from the State Water Control Board, or (iii) source, special nuclear, or by-product material as defined by the Federal Atomic Energy Act of 1954, as amended.

"Solid waste management" means the systematic administration of activities that provide for the collection, source separation, storage, transportation, transfer, processing, treatment, and disposal of solid wastes whether or not such facility is associated with facilities generating such wastes or otherwise.

"Spill" means any accidental or unpermitted spilling, leaking, pumping, pouring, emitting, or dumping of wastes or materials that, when spilled, become wastes.

"Start-up" or "cold start-up" means the beginning of a combustion operation from a condition where the combustor unit is not operating and less than 140° F. in all areas.

"Storage" means the holding, including during transportation, of more than 64 gallons of waste, at the end of which the regulated medical waste is treated, disposed, or stored elsewhere. Storage also means the transfer of a load of regulated medical waste from one vehicle to another during transportation, or the parking of a vehicle containing regulated medical waste during transport for 24 hours or more.

"Training" means formal instruction, supplementing an employee's existing job knowledge, designed to protect human health and the environment via attendance and successful completion of a course of instruction in regulated medical waste management procedures, including contingency plan implementation, relevant to those operations connected with the employee's position at the facility.

"Transfer facility" means any transportation related facility including loading docks, parking areas, storage areas, and other similar areas where shipments of regulated medical waste are held during the normal course of transportation.

"Transportation" means the movement of regulated medical waste by air, rail, highway, or water.

"Transport vehicle" means any vehicle used for the transportation of cargo.

"Vector" means a living animal, insect or other arthropod that may transmit an infectious disease from one organism to another.

"VRGTHM" means Virginia Regulations Governing the Transportation of Hazardous Materials promulgated by the Virginia Waste Management Board as authorized by §§ 10.1-1450 through 10.1-1454 of the Code of Virginia.

"Waste generation" means the act or process of producing a regulated medical waste.

"Waste management facility" means all contiguous land and structures, other appurtenances, and improvements thereon used for treating, storing, and disposing of waste.

"Waste management unit" means any unit at a treatment, storage or disposal facility that is seeking or possesses a permit, or that has received regulated medical waste (as defined in these regulations) at any time, including units that are not currently active.

PART II. LEGISLATIVE AUTHORITY AND GENERAL INFORMATION.

§ 2.1. Authority for regulations.

These regulations are issued pursuant to the Virginia Waste Management Act, Chapter 14 (§ 10.1-1400 et seq.) of Title 10.1 of the Code of Virginia (hereinafter Code) which authorizes the Virginia Waste Management Board to promulgate and enforce such regulations as may be necessary to carry out its duties and powers and the intent of that chapter the Virginia Waste Management Act and the federal acts.

§ 2.2. Purpose of regulations.

The purpose of these regulations is to establish standards and procedures pertaining to regulated medical waste management in this Commonwealth in order to protect the public health and public safety, and to enhance the environment and natural resources.

§ 2.3. Administration of regulations.

A. The Virginia Waste Management Board promulgates and enforces regulations that it deems necessary to protect the public health and safety, the environment, and natural resources.

B. The director is authorized to issue orders to require any person to comply with these regulations or to require such steps as he deems necessary to bring about compliance. Orders shall be issued in writing through certified mail and shall be issued in accordance with provisions of applicable law. Nothing contained in these regulations shall be considered to prevent or curtail the director in the exercise of any power granted to that office by statute, executive order, or separate action of the board.

§ 2.4. Applicability of regulations.

A. These regulations apply to all persons who manage regulated medical waste, own or operate regulated medical waste management facilities or allow regulated medical waste management facilities to be operated on their property in this Commonwealth, to those who seek approval to engage in these activities and to all persons who manage regulated medical wastes, except those specifically exempted or excluded elsewhere in these regulations.

B. All existing regulated medical waste management facilities, including those under a permit on [the effective date of these regulations June 29, 1994], must comply with these regulations, except as provided in this section. [Existing permits will remain valid, except that conditions or waivers in existing permits that conflict with these amended regulations are void on the date six months from the effective date of these amended regulations. Any regulated medical waste management facility that is in operation on July 1, 1994, may delay until July 1, 1995, compliance with any requirement contained in these regulations that was not a requirement

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of "Regulated Medical Waste Management Regulations, VR 672-40-01" (emergency regulations effective June 30, 1993).]

§ 2.5. Severability.

A. The board intends that these regulations be severable, so that if any provision or part of these regulations is held invalid, unconstitutional or inapplicable to any person or circumstances, such invalidity, unconstitutionality or inapplicability shall not affect or impair the remaining provisions of these regulations and their application.

B. These regulations supersede and replace all previous regulations of the Waste Management Board to the extent that those prior regulations conflict with the regulations presented herein. Where there does not exist a conflict between the prior regulations and those presented herein, no replacement shall be deemed to occur and the prior regulations shall remain. These regulations supersede and replace in their entirety previous rules of the board: "Infectious Waste Management Regulations, effective May 2, 1990 and "Regulated Medical Waste Management Regulations" effective June 30, 1993.

C. These regulations shall remain in effect until the Virginia Waste Management Board shall amend, rescind or otherwise alter them. Where there appears to be a conflict between these regulations and other regulations adopted at a future date, and such future regulations do not specifically clarify these regulations, these regulations shall be controlling.

D. These regulations are completely separate from all federal or local governmental regulations.

§ 2.6. Relationship to other bodies of regulation.

A. The Solid Waste Management Regulations address special needs for regulated medical waste management. Any regulated medical waste management facility must also conform to any applicable sections of the solid waste management regulations issued by the board and any special solid waste management regulations such as those defining financial assurance requirements. If there is a conflict between the details of regulations herein and the others, these regulations are controlling.

B. Any regulated medical waste management facility must also comply with any applicable sections of the Hazardous Waste Management Regulations issued by the department. If there is a conflict between the details of regulations herein and the hazardous waste management regulations, the latter regulations are controlling.

C. Intrastate shipment of hazardous materials are subject to the Hazardous Materials Transportation Regulations of the department. If there is a conflict between the details of regulations herein and the hazardous materials transportation regulations, the latter

are controlling.

D. If there is a conflict between the regulations herein and adopted regulations of another agency of the Commonwealth, the provisions of these regulations are set aside to the extent necessary to allow compliance with the regulations of the other agency.

E. Nothing herein either precludes or enables a local governing body to adopt ordinances. Compliance with one body of regulation does not insure compliance with the other, and, normally, both bodies of regulation must be complied with fully.

PART III. IDENTIFICATION AND LISTING OF REGULATED MEDICAL WASTES.

Article 1. General.

§ 3.1. Purpose and scope.

[A. This part contains general provisions in §§ 3.1 and 3.2, a description of persons exempt in all or in part from the regulations in § 3.5, a description of waste and materials excluded from consideration in these regulations in § 3.6, and the definition of regulated medical waste in §§ 3.7 and 3.8.

B. The intent of §§ 3.1 and 3.2 is to establish the part as defining regulated medical waste and to establish rules for wastes that were once regulated medical waste, but are no longer defined to be regulated medical waste because of treatment, recycling, reuse, or other reasons.]

[~~A. C.~~] Wastes identified in Part III are regulated medical wastes, which are subject to Virginia Regulated Medical Waste Management Regulations.

[~~B. D.~~] The basic definition of solid waste appears in Part I along with other pertinent definitions and shall be referred to for the exact meaning of the terms used. Additional detailed descriptions of regulated medical wastes, exclusions and listings required to arrive at the proper classification of wastes are the subject of this part.

§ 3.2. Materials rendered nonregulated.

Wastes that were once regulated and were managed in accord with these regulations, and that are no longer regulated medical waste, shall be managed in accordance with such other regulations of the board that apply.

1. Packaging. Treated waste that was once regulated, but is no longer regulated medical waste, shall [~~bear a label until it is disposed clearly indicating that it is not regulated and an explanation why it is no longer regulated~~ not be packaged as regulated medical waste] . Solid waste packaged as regulated medical waste is regulated medical waste.

2. *Recordkeeping.* If the solid waste is no longer regulated medical waste because of treatment, the generator or permitted facility shall maintain a record of the treatment for three years afterward to include the date and type of treatment, type and amount of regulated medical waste treated, and the individual operating the treatment. Records for on-site treatment and shipping papers from commercial carriers for off-site treatment shall be maintained by the generator. Records for off-site treatment and shipping papers for off-site treatment shall be maintained by all permitted facilities. Generators or permitted facilities with more than one unit may maintain a centralized system of recordkeeping. All records shall be available for review upon request.

§ 3.3. Recycled materials.

A. *Untreated regulated medical wastes shall not be used, reused, or reclaimed; however, wastes that have been sterilized, treated or incinerated in accord with these regulations and are no longer regulated medical waste may be used, reused, or reclaimed.*

B. *Bed linen, instruments, medical care equipment and other materials that are routinely reused for their original purpose are not subject to these regulation until they are discarded and are a solid waste. These items do not include reusable carts or other devices used in the management of regulated medical waste (See § 5.6).*

§ 3.4. Documentation of claims that materials are not solid wastes or are conditionally exempt from regulation.

Respondents in actions to enforce these regulations who raise a claim that a certain material is not a solid waste, or is conditionally exempt from regulation, shall demonstrate that they meet the terms of the exclusion or exemption. In doing so, they shall provide appropriate documentation to demonstrate that the material is not a waste, or is exempt from regulation.

Article 2. Exemptions and Exclusions.

§ 3.5. Exemptions to the regulations.

Exemptions to these regulations include:

1. *Composting of sewage sludge at the sewage treatment plant of generation and not involving other solid wastes.*
2. *Land application of wastes regulated by the State Board of Health, the State Water Control Board, or any other state agency with such authority.*
3. *Wastewater treatment or pretreatment facilities permitted by the State Water Control Board by a NPDES permit.*

4. *Management of hazardous waste as defined and controlled by the Virginia Hazardous Waste Management Regulations to the extent that any requirement of those regulations is in conflict with regulations herein.*

5. [*Persons who qualify under the rules of subdivision 5 of § 3.5 are partially exempt from the regulations to the extent contained in subdivision 6 of § 3.5.] *Health care professionals [or microbiological laboratory managers] who generate regulated medical waste in the provision of health care services in their own office, in the private home of a patient, or in a limited small clinic are exempt from those parts of the regulations listed in subdivision 6 of § 3.5 provided the regulated medical waste is disposed of as authorized below:**

a. *With respect to regulated medical waste other than sharps, the office, clinic or the patient's home does not accumulate sufficient regulated medical waste to create a storage facility as regulated by Part V, the regulated medical waste is packaged and labeled in accord with Part IV, and the regulated medical waste is delivered to a permitted regulated medical waste treatment or storage facility in accordance with Part VI, except as exempted by subdivision 6 of § 3.5.*

b. *With respect to sharps, the sharps are packaged in rigid, highly leak resistant and highly puncture resistant containers and labeled in accord with Part IV, and before filled to capacity, such containers are delivered to a permitted regulated medical waste treatment or storage facility.*

c. *The health care professional [or microbiological laboratory manager] transports or arranges for the transportation of the regulated medical waste:*

(1) *Himself or herself, or by his or her employee (who is also a health care professional [or microbiological laboratory manager]), or*

(2) *By a transporter registered as such with the Department of Environmental Quality.*

d. *Notwithstanding any provisions to the contrary in these regulations, regulated medical waste transported pursuant to subdivision 5 c (1) of this section shall be exempt from subdivision 4 of § 4.6 of these regulations.*

e. *The regulated medical waste is not held in the office, the limited small clinic, or the patient's home for more than seven days after it is generated.*

6. *Persons qualifying under subdivision 5 of § 3.5 shall be exempt from §§ 4.12, 4.13, 4.14, 4.16 A, [4.17] and 6.1 through 6.9 of these regulations, unless otherwise [required limited] by subdivision 5 of §*

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3.5.

§ 3.6. Exclusions.

[A. Materials described in this section may be partially or totally excluded from these regulations because they are not solid waste, not regulated medical waste or regulated medical waste the board excludes from these regulations.]

[A. B.] The following materials are not solid wastes for the purposes of this part:

1. Domestic sewage, including wastes that are not stored and are disposed of in a sanitary sewer system (with or without grinding);
2. Any mixture of domestic sewage and other wastes that pass through a sewer system to a wastewater treatment works permitted by the State Water Control Board or the State Department of Health;
3. Human remains under the control of a licensed physician or dentist, when the remains are being used or examined for medical purposes and are not solid wastes; and
4. Human remains properly interred in a cemetery or in preparation by a licensed funeral director or embalmer for such interment or cremation.

[B. C.] The following solid wastes are not regulated medical wastes:

1. Meat or other food items being discarded because of spoilage or contamination, and not included in § 3.8.
2. Garbage, trash [,] and sanitary waste from septic tanks and sewage holding tanks [; generated at] single or multiple residences, hotels, motels, bunkhouses, ranger stations, crew quarters, campground, picnic grounds and day-use recreation areas, except for regulated medical waste generated by the provision of professional health care services on the premises, provided that all medical sharps shall be placed in a opaque container with a high degree of puncture resistance before being mixed with other wastes or disposed.

[C. D.] The following regulated medical wastes are not subject to the requirements of these regulations when dispersed among other wastes and not accumulated separately:

1. Used products for personal hygiene, such as diapers, facial tissues and sanitary napkins.
2. Material, not including sharps, containing small amounts of blood or body fluids, but containing no free flowing or unabsorbed liquid.

Article 3. Characteristics.

§ 3.7. Characteristics of regulated medical waste.

A solid waste is a regulated medical waste if it meets either of the two criteria of this section:

1. Any solid waste, as defined in these regulations is a regulated medical waste if it is suspected by the health care professional in charge of being capable of producing an infectious disease in humans. A solid waste shall be considered to be capable of producing an infectious disease if it has been or is likely to have been contaminated by an organism likely to be pathogenic to healthy humans, such organism is not routinely and freely available in the community, and if such organism has a significant probability of being present in sufficient quantities and with sufficient virulence to transmit disease. If the exact cause of a patient's illness is unknown, but the health care professional in charge suspects a contagious disease is the cause, the likelihood of pathogen transmission shall be assessed based on the pathogen suspected of being the cause of the illness.

2. Any solid waste that is not excluded from regulation is a regulated medical waste if it is listed in § 3.8 of these regulations.

Article 4. Controlled Regulated Medical Wastes.

§ 3.8. Lists of controlled regulated medical wastes.

In addition to wastes described by the characteristics set forth in § 3.7, each solid waste or solid waste stream on the following lists is subject to these regulations, unless exempted in § 3.5 or excluded in § 3.6 of these regulations.

1. Cultures and stock of microorganisms and biologicals. Discarded cultures, stocks, specimens, vaccines and associated items likely to have been contaminated by them are regulated medical wastes if they are likely to contain organisms likely to be pathogenic to healthy humans. Discarded etiologic agents are regulated medical waste. Wastes from the production of biologicals and antibiotics likely to have been contaminated by organisms likely to be pathogenic to healthy humans are regulated medical wastes.

2. Blood and blood products. Wastes consisting of human blood, human blood products (includes serum, plasma, etc.) and items contaminated by human blood are regulated medical waste.

3. [~~Pathological~~ Tissues and other anatomical] wastes. All [~~pathological~~ human anatomical] wastes and all wastes that are human tissues, organs, body

parts, or body fluids are regulated medical waste.

4. Sharps. Sharps likely to be contaminated with organisms that are pathogenic to healthy humans, and all sharps used in patient care or veterinary practice are regulated medical wastes.

5. Animal carcasses, body parts, bedding and related wastes. When animals are intentionally infected with organisms likely to be pathogenic to healthy humans for the purposes of research, in vivo testing, production of biological materials or any other reason; the animal carcasses, body parts, bedding material and all other wastes likely to have been contaminated are regulated medical wastes when discarded, disposed of or placed in accumulated storage.

6. Any residue or contaminated soil, water, or other debris resulting from the cleanup of a spill of any regulated medical waste.

7. Any solid waste contaminated by or mixed with regulated medical waste.

PART IV. GENERAL REQUIREMENTS.

Article 1.

Permits and [On-site] Permits By Rule.

§ 4.1. Permit required.

No person who is subject to these regulations shall treat, store, or dispose of regulated medical waste without a permit from the department to engage in those activities.

§ 4.2. Persons required to have a permit.

Any person required to have a permit for facilities for the management of regulated medical waste shall make [~~a formal~~ an] application for a permit in accord with Part X of these regulations, with the exception that certain facilities may be deemed to have [~~a~~ an on-site] permit by rule in accord with § 4.3 of these regulations. [The accumulation of regulated medical waste in bulk transport containers or on loading docks shall not require the operator to hold either an on-site permit by rule or a permit under Part X of these regulations if:

1. Those facilities merely facilitate transportation and do not involve holding of waste for more than seven days, and
2. No more than 25% of the regulated medical waste received is generated off-site or the site is exclusively a collection point for nonstationary health care providers and is not owned or operated by a vendor of waste management services.

This exemption of permitting requirements does not

include or imply any exemption from the design and operation standards contained in Part V or elsewhere in these regulations.]

§ 4.3. Persons qualifying for [~~a~~ an on-site] permit by rule.

Qualifying facilities are deemed to operate under a permit for regulated medical waste management activities and their owners or operators are not required to comply with the permit issuance procedures of Part X of these regulations. While persons who own or operate qualifying facilities are not subject to Part X or required to have a written permit from the department for those qualifying facilities, they are subject to these regulations and all other parts thereof. If a person owns or operates a regulated medical waste management unit that does not qualify for [~~a~~ an on-site] permit by rule, that person must comply with Part X and all other parts of these regulations for those units, without regard to the presence of any other units on the site that are operated under a permit by rule. Only those units that are in complete compliance with all the following conditions are qualified and considered to be under [~~a~~ an on-site] permit by rule for their operation, and no [on-site] permit by rule shall exist for a facility failing to fulfill any of the following conditions:

1. The facility and all regulated medical waste activities are in compliance with all parts of these regulations except Part X.
2. More than 75% (by weight, in a calendar year) of all regulated medical waste that is stored, treated or disposed of by the facility is generated on-site or the site is exclusively a collection point for nonstationary health care providers and is not owned or operated by [a] vendor of waste management services.
3. No regulated medical waste is transported from or received by the facility without being properly packaged and labelled in accordance with these regulations.
4. The activities at the facility do not involve the placing of regulated medical waste directly into or on the land.
5. The owner or operator of the facility has notified the director in writing that the facility is operating under [~~a~~ an on-site] permit by rule. The notice shall give the name of the facility; the mailing address of the facility; the location address of the facility; the type of business the facility serves; the type of facilities (treatment, storage, transportation, disposal) involving regulated medical waste; and the name, address and telephone number of the principal corporate officer.
6. The owner or operator of the facility has submitted to the director a certification from the local governing

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body (city, county, or town in which the facility is to be located) stating; without qualifications, conditions, or reservations; that the location and operation of the facility are consistent with all applicable ordinances.

7. The owner or operator of the facility has submitted to the director appropriate Key Personnel Disclosure Statements.

Article 2. Financial Assurance.

§ 4.4. Financial assurance requirements.

The department has adopted and will maintain separate regulation, Financial Assurance Regulations For Solid Waste Facilities, which shall be applicable in all parts to regulated medical waste management facilities. Nothing in these regulations governing regulated medical waste management shall be considered to delete or alter any requirements of the department as set out in Financial Assurance Regulations For Solid Waste Facilities.

Article 3. Packaging and Labeling Requirements for Regulated Medical Waste.

§ 4.5. Responsibility for packaging and labeling.

A. The generator of regulated medical waste is responsible for the packaging and labeling of regulated medical wastes. As a bag becomes full, it must be sealed, packaged, labeled and managed as described in these regulations. Contractors or other agents may provide services to the generator, including packaging and labeling of regulated medical waste, however, no contract or other relationship shall relieve the generator of the responsibility for packaging and labeling the regulated medical waste as required by these regulations.

B. No person shall receive for transportation, storage, treatment or disposal any regulated medical waste that is not packaged in accord with these regulations. Contractors or other agents may package or repack regulated medical wastes to comply with these regulations, if the packaging or repackaging is performed on-site where the regulated medical waste was generated and no transportation, storage, treatment or disposal occurs prior to the packaging or repackaging. Nothing in this section shall prevent the proper repackaging and further transportation of regulated medical waste that has spilled during transportation.

§ 4.6. Packaging prior to storage, treatment, transport or disposal.

All regulated medical waste shall be packaged as follows before it is stored, treated, transported or disposed of:

1. Regulated medical wastes shall be contained in two

highly leak resistant, plastic bags each capable of passing the ASTM 125 pound [~~Drop Test For Filled Bags (D959)~~ Standard Test Method for Drop Test of Loaded Containers by Free Fall, D5276-92,] and each sealed separately, or one highly leak resistant, plastic bag inside a rigid container. Free liquids shall be contained in sturdy highly leak resistant containers that resist breaking; heavy materials must be supported in boxes. Sharps shall be collected at the point of generation in highly puncture resistant containers, and those containers closed and placed inside a plastic bag prior to storage or transport.

2. All bags containing regulated medical waste shall be red in color. Waste contained in red bags shall be considered regulated medical waste and managed as regulated medical waste.

3. Bags shall be sealed by lapping the gathered open end and binding with tape or closing device such that no liquid can leak.

4. In addition to the plastic bag containers described in this section, all regulated medical wastes must be enclosed in a rigid container before it is transported off-site or in a vehicle on a street or highway. The box or container must meet the [performance] standards of (1993) 49 CFR 171 through 178 [~~for a classified strength of at least 275 pounds per square inch using the Mullen Test or 48 pounds per inch using the Edge Crush Test~~] .

[~~Note: The Mullen test is T 810 om-80, Bursting Strength of Corrugated and Solid Fiberboard, by the Technical Association of the Pulp and Paper Industry, P. O. Box 105113, Atlanta, GA 30348. The Edge Crush Test is D 2808, Standard Test Method for Compressive Strength of Corrugated Fiberboard (Short Column Test), by the American Society for Testing and Materials, 1916 Race Street, Philadelphia, PA 19013.~~]

§ 4.7. Labeling requirements.

All regulated medical waste shall be labeled immediately after packaging. The label shall be securely attached to the outer layer of packaging and be clearly legible. The label may be a tag securely affixed to the package. Indelible ink shall be used to complete the information on the label, and the label shall be at least three inches by five inches in size. The following information shall be included:

1. The name, address and business telephone number of the generator and the date on which the bag of regulated medical waste was discarded.

2. "Regulated Medical Waste" in large print.

3. The name, address and business telephone number of all transporters or other persons to whose control

the regulated medical waste is transferred.

4. The Biological Hazard Symbol.



§ 4.8. Etiological agents.

All etiological agents, as defined in (1993) 49 CFR 171 through 178, that are transported must be packaged as described in (1993) 49 CFR 171 through 178 and labeled as described in (1993) 49 CFR 171 through 178, even when that transport is wholly within the boundaries of the Commonwealth.

§ 4.9. Sharps.

Sharps must be placed directly into rigid and highly puncture resistant containers.

§ 4.10. Protection of packagers.

Persons packaging regulated medical waste shall wear heavy gloves of neoprene or equivalent materials and other appropriate items of personal protection equipment. [As a minimum, other appropriate equipment shall include that recommended in "CDC Guidelines for Isolation Precautions in Hospitals" (1983) by the Center for Disease Control, Hospital Infections Program, Center for Infectious Diseases.]

§ 4.11. Special requirements for reusable containers.

Regulated medical waste may be conveyed in reusable carts or containers under the following conditions:

1. The waste in the cart or container is packaged fully in accordance with §§ 4.6 through 4.9. [~~Discrete units of waste and the cart or container must be properly labeled in accordance with § 4.7.~~ Discrete packages of waste and the cart or container shall each be properly labeled in accordance with § 4.7.]

2. Immediately following each time a reusable cart or container is emptied and prior to being reused it is thoroughly cleaned, rinsed and effectively disinfected with a hospital grade disinfectant effective against mycobacteria. The area where carts or containers are cleaned, rinsed or disinfected is a storage area and regulated under Part V of these regulations.

3. Unloading of reusable carts or containers that contain regulated medical waste should be accomplished by mechanical means and not require handling of bags or packages by humans. [Mechanical means can consist of tipping floors, chutes, snares and other simple mechanisms.]

4. When reusable carts or containers containing regulated medical waste are used for off-site transport, all aspects of the cart or container management shall comply with § 6.11 of these regulations.

Article 4.

Management of Spills of Regulated Medical Waste.

§ 4.12. Spill containment and cleanup kit.

All regulated medical waste management facilities are required to keep a spill containment and cleanup kit within the vicinity of any area where regulated medical wastes are managed, and the location of the kit shall provide for rapid and efficient cleanup of spills anywhere within the area. All vehicles transporting regulated medical wastes are required to carry a spill containment and clean up kit in the vehicle whenever regulated medical wastes are conveyed. The kit shall consist of at least the following items:

1. Material designed to absorb spilled liquids. The amount of absorbent material shall be that having a capacity, as rated by the manufacturer, of one gallon of liquid for every cubic foot of regulated medical waste that is normally managed in the area for which the kit is provided or 10 gallons, whichever is less.

2. One gallon of disinfectant in a sprayer capable of dispersing its charge in a mist and in a stream at a distance. The disinfectant shall be hospital grade and effective against mycobacteria.

3. Enough red plastic bags to double enclose 150% of the maximum load accumulated or transported (up to a maximum of 500 bags), that meet the ASTM 125 pound Drop Test For Filled Bags (D959) and are accompanied by sealing tape (or devices) and labels (or tags). These bags shall be large enough to overpack any box or other container normally used for regulated medical waste management by that facility.

4. Two new sets of liquid impermeable and disposable overalls, gloves, boots, caps and protective breathing devices. Overalls, boots and caps shall be oversized or fitted to regulated medical waste workers. Boots may be of thick rubber and gloves shall be of heavy neoprene or equivalent (Boots, gloves, and breathing devices; may be reused if fully disinfected between uses). Protective breathing devices shall be approved for filtering particulates and mists; usually, disposable surgical masks will suffice. Tape for sealing openings at wrists and ankles shall also be in the kit.

5. A first aid kit, fire extinguisher, boundary marking tape, lights and other appropriate safety equipment.

§ 4.13. Containment and clean up procedures.

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[A.] Following a spill of regulated medical waste or its discovery, the following procedures shall be implemented:

1. Leave the area until the aerosol settles (no more than a few minutes delay).
2. The clean up crew will don the cleanup outfits described in subdivision 4 of § 4.12 and secure the spill area.
3. Spray the broken containers of regulated medical waste with disinfectant.
4. Place broken containers and spillage inside overpack bags in the kit, minimizing exposure.
5. Disinfect the area and take other cleanup steps deemed appropriate.
6. Clean and disinfect nondisposable items.
7. Clean and disinfect cleanup outfits before removing.
8. Remove cleanup outfits and place disposable items in cleanup bag.
9. Take necessary steps to replenish containment and cleanup kit with items used.

[~~C. B.~~] When a spill involves only a single container of regulated medical waste whose volume is less than 32 gallons and spilled liquid whose volume is less than one quart, the individual responsible for the cleanup may elect to use alternate appropriate dress and procedures than those described in §§ 4.12 and 4.13. Such alternate dress or procedures shall provide an protection of the health of workers and the public equivalent to that described above.

Article 5. Closure Requirements.

§ 4.14. Closure requirements.

When a unit that has been used for regulated medical waste management is to cease operations involving regulated medical wastes, it shall be thoroughly cleaned and disinfected. All regulated medical waste shall be disposed of in accord with these regulations, and items of equipment shall be disinfected.

Article 6. Treatment and Disposal.

§ 4.15. Methods of treatment and disposal.

A. All regulated medical waste must be incinerated, sterilized by steam, [or] treated by a method as described in Part VII, VIII, or IX of these regulations.

B. No regulated medical waste shall be disposed of in a

solid waste landfill or other solid waste management facility. Upon authorized treatment and management in accord with these regulations, the solid waste or its ash is not regulated medical waste and may be disposed of at any landfill or other solid waste management facility permitted to receive putrescible solid waste or garbage, provided the disposal is in accordance with the Solid Waste Management Regulations, VR 672-20-10, and other applicable regulations and standards.

[~~C. Pathological wastes and bulk liquids must be dispersed in other regulated medical waste when treated and not concentrated. Pathological wastes and bulk liquids shall not constitute more than 10% by weight of any load to a unit providing treatment. However, this requirement does not prohibit the disposal, without storage and with or without grinding, of wastes, including blood and body fluids, in a sanitary sewer system.~~]

[~~D. C.~~] Regulated medical waste in closed bags or containers shall not be compacted or subjected to violent mechanical stress; however, after it is fully treated and it is no longer regulated medical waste, it may be compacted in a closed container. Nothing in this section shall prevent the puncturing of containers or packaging immediately prior to permitted treatment in which grinding, shredding, or puncturing is integral to the process units [and, provided the puncturing is performed in a ; however, all grinding, shredding and puncturing, shall be done with] safe and sanitary [method methods] . Devices that grind, shred, compact or reduce the volume of regulated medical waste may be employed at the point of generation and prior to enclosing the regulated medical waste in plastic bags and other required packaging; however, the waste remains regulated medical waste.

Article 7. Recordkeeping.

§ 4.16. Recordkeeping requirements.

A. All generators and regulated medical waste management facilities that manage regulated medical waste shall maintain the following records and assure that they are accurate and current:

1. A list of the members of any [~~ad hoc~~] committee for the management of infection control for the facility, their address, their phone numbers and the period of their membership.
2. The date, persons involved and short description of events in each spill of regulated medical wastes involving more than 32 gallons of regulated medical waste or one quart of free liquid.
3. A notebook or file containing the adopted policies and procedures of the facility for dealing with regulated medical wastes.
4. A log of all special training received by persons

involved in regulated medical waste management.

5. A log of regulated medical waste received from off-site, the generator, the amount and its generation and receipt dates. Records shall be maintained for a period of three years and be available for review.

B. All regulated medical waste management facilities shall maintain the following records and assure that they are accurate and current:

1. A signed certificate for each load received in which the generator affirms that the load does not contain hazardous waste (including cytotoxic medications) or radioactive materials, except as provided in § 4.17; or

2. A signed and effective contract, inclusive of all loads received from a generator, in which the generator affirms that all loads will not contain hazardous waste (including cytotoxic medications) or radioactive materials, except as provided in § 4.17.

Article 8.

Radioactive Materials.

§ 4.17. Management of radioactive materials.

The United States Nuclear Regulatory Commission (USNRC) has established regulations under Title 10 of the Code of Federal Regulations for the management of radioactive materials. The Virginia Department of Health has established other requirements in accordance with Title 32.1 of the Code of Virginia. No regulated medical waste containing radioactive materials, regardless of amount or origin, shall be treated unless its management and treatment are in full compliance with these two bodies of regulations and are deemed by both regulations not to represent a threat to public health and the environment.

[Article 9.

Quarterly Reporting.

§ 4.18. Quarterly reporting by facilities.

Operators of regulated medical waste management facilities that receive more than 100 pounds in any month of regulated medical waste from off-site shall file a written report of regulated medical waste amounts received during the preceding quarter on the tenth business day of January, April, July, and October of each year. The report shall contain:

1. The name, mailing address, physical location, and telephone number of the firm;

2. The name and signature of the person preparing the report;

3. Each city, county, and town (including the state) from which regulated medical waste was received

during the quarter and the total amount (in tons) received from each point of origin; and

4. Each city, county, and town (including the state) to which regulated medical waste was shipped during the quarter and the total amount (in tons) sent to each point of destination.]

PART V.

SPECIAL REQUIREMENTS FOR STORAGE FACILITIES.

§ 5.1. Application of Part V.

The requirements of this part apply only to areas of storage where more than 64 gallons of regulated medical waste are accumulated, including storage of regulated medical waste during transportation and at incinerator, steam sterilization and other treatment and disposal facilities.

§ 5.2. Sanitation.

All areas used to store regulated medical waste must be clean and impermeable to liquids. Carpets and floor coverings with seams shall not be used in storage area. Vectors shall be controlled.

§ 5.3. Access.

All areas used to store regulated medical waste must have access control that limits access to those persons specifically designated to manage regulated medical waste.

§ 5.4. Temperature control and storage period.

Any regulated medical waste that is more than seven days past its date of generation and is stored must be refrigerated, stored in an ambient temperature between 35° and 45° Fahrenheit (2° and 7° Celsius). No regulated medical waste shall be stored for more than 30 days.

§ 5.5. Drainage and ventilation.

All floor drains shall discharge directly to an approved sanitary sewer system. All ventilation shall discharge so as to minimize human exposure to the effluent. [Transfer of regulated medical waste between a vehicle and another vehicle or between vehicle and a structure shall occur under a roof that protects the operation from rainfall and over a floor or bermed pavement that will contain leaks and spills of liquids from the waste, unless the transfer involves less than 64 gallons of regulated medical waste during a 24 hour period. Storage, transport and transfer to, from, and between vehicles shall be under a cover that protects the waste containers from rainfall and over a floor or bermed pavement that will contain leaks and spills of liquid from the waste. No requirement for cover, floor, or pavement shall be construed if the activity is transient in nature, such as in the case of spill cleanup or weekly collection of waste packages from professional

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offices for transport.]

§ 5.6. Facilities for management of reusable carts or containers.

Waste managed in reusable carts or containers shall meet the following requirements:

1. The regulated medical waste in the cart or container shall be packaged fully in accordance with §§ 4.6 through 4.9. Discrete units of regulated medical waste and the cart or container must be properly labeled.

2. Immediately following each time a reusable cart or container is emptied and prior to being reused it shall be thoroughly cleaned, rinsed and effectively disinfected with a hospital grade disinfectant. The disinfectant must be in used in accord with manufacturer's direction and effective against mycobacteria.

3. Unloading of reusable carts or containers that contain regulated medical waste not contained in non-reusable rigid containers should be accomplished by mechanical means and not require handling of packages by humans. [Mechanical means can consist of tipping floors, chutes, snares and other simple mechanisms.]

4. The area where cleaning, rinsing, and disinfecting occurs is a storage area and shall comply with all other sections of Part V.

§ 5.7. Container management.

Persons loading, unloading, or handling containers of regulated medical waste shall wear clean, heavy neoprene (or equivalent) gloves and clean uniforms.

PART VI.

SPECIAL REQUIREMENTS FOR TRANSPORTATION.

§ 6.1. Application of Part VI.

The requirements of this part apply to all transportation of regulated medical waste.

§ 6.2. Sanitation.

Surfaces of equipment used to transport regulated medical waste must be clean and impermeable to liquids, if those areas are involved with the management of the waste. Carpets and floor coverings with seams shall not be used. Vectors shall be controlled. All trucks and equipment used to transport regulated medical waste must be thoroughly cleaned and disinfected before being used for any other purpose, at the end of each business day or 24-hour period of use, and prior to any transfer of ownership.

§ 6.3. Access.

All vehicles, equipment and service or parking areas used in the transportation of regulated medical waste must have access control that limits access to those persons specifically designated to manage regulated medical waste.

§ 6.4. Temperature control and storage period.

Any regulated medical waste that is more than seven days past its date of generation and is transported must be refrigerated, maintained in an ambient temperature between 35° and 45° Fahrenheit (2° and 5° Celsius), during transport and during any storage following transport. No regulated medical waste shall be stored for more than 30 days. Time in transport shall be accounted as time in storage.

§ 6.5. Drainage.

All drainage shall discharge directly or through a holding tank to an approved sanitary sewer system. [All transfers of regulated medical waste between a vehicle and another vehicle or between vehicle and a structure shall occur under a roof that protects the operation from rainfall and over a floor or bermed pavement that will contain leaks and spills of liquids from the waste, unless the transfer involves less than 64 gallons of regulated medical waste during a 24 hour period. Storage, transport and transfer to, from, and between vehicles shall be under a cover that protects the waste containers from rainfall and over a floor or bermed pavement that will contain leaks and spills of liquid from the waste. No requirement for cover, floor, or pavement shall be construed if the activity is transient in nature, such as in the case of spill cleanup or weekly collection of waste packages from professional offices for transport.]

§ 6.6. Packaging, labeling and placards.

A. No person shall transport or receive for transport any regulated medical waste that is not packaged and labeled in accord with Part IV of these regulations.

B. The access doors to any area holding regulated medical waste in transport shall have a warning sign in bold and large letters that indicates the cargo is regulated medical waste.

[C. Transportation vehicles must bear placards depicting the international symbol for biologically hazardous materials (See § 4.7). Placards shall conform to standards of the United States Department of Transportation specified in (1993) 49 CFR 172 Subpart F regarding size, placement, color and detail.]

§ 6.7. Management of spills of regulated medical waste.

A. All vehicles transporting regulated medical wastes are required to carry a spill containment and clean up kit

in the vehicle whenever regulated medical wastes are conveyed. The kit shall consist of at least the following items:

1. Material designed to absorb spilled liquids. The amount of absorbent material shall be rated by the manufacture as having a capacity to absorb 10 gallons.

2. One gallon of disinfectant in a sprayer capable of dispersing its charge in a mist and in a stream at a distance. The disinfectant shall be hospital grade and effective against mycobacteria.

3. Enough red plastic bags to double enclose 150% of the maximum load accumulated or transported (up to a maximum of 500 bags) that meet the ASTM 125 pound Drop Test For Filled Bags (D959) and are accompanied by seals and labels. These bags shall be large enough to overpack any box or other container normally used for regulated medical waste management.

4. Two new sets of disposable overalls, gloves, boots, caps and breathing protective devices. Overalls, boots and caps shall be oversized or fitted to regulated medical waste workers and be made of materials impermeable to liquids. Boots may be of thick rubber and gloves shall be of heavy neoprene or equivalent (Boots, gloves and breathing devices, may be reused if fully disinfected between uses). Protective breathing devices shall be approved for filtering particulates and mists; disposable surgical masks will suffice. Tape for sealing openings at wrists and ankles shall also be in the kit.

5. A first aid kit, fire extinguisher, boundary marking tape, lights and other appropriate safety equipment.

B. Following a spill of regulated medical waste or its discovery, the following procedures shall be implemented:

1. Leave the area until the aerosol settles (no more than a few minutes delay).

2. The clean up crew will don the clean up outfits described in subdivision A 4 of this section and secure the spill area.

3. Spray the broken containers of regulated medical waste with disinfectant.

4. Place broken containers and spillage inside the overpack bags in the kit, minimizing exposure.

5. Disinfect the area and take other clean up steps deemed appropriate.

6. Clean and disinfect clean up outfits before removing.

7. Clean and disinfect nondisposable items.

8. Remove clean up outfits and place disposal items in clean up bag.

9. Take necessary steps to replenish containment and clean up kit with items used.

C. When a spill involves only a single container of regulated medical waste whose volume is less than 32 gallons and spilled liquid whose volume is less than one quart, the individual responsible for the clean up may elect to use alternate appropriate dress and procedures. Such alternate dress or procedures shall provide protection of the health of workers and the public equivalent to that described above.

§ 6.8. Loading and unloading.

Persons loading and unloading transportation vehicles with regulated medical waste shall wear clean, heavy neoprene (or equivalent) gloves and clean uniforms.

§ 6.9. Registration of transporters.

A. At least 30 days prior to transporting any regulated medical waste within the Commonwealth, all transporters must register with the Department of Environmental Quality. Registration shall consist of filing the data specified in subsection B of this section, in written form, and the department will issue a registration number to the transporter. No regulated medical waste shall be transported until the registration number is issued. Transporters shall notify the generator of the waste of his registration number when he collects the waste.

B. Data to be submitted by persons wishing to register as a transporter of regulated medical waste shall be as follows:

1. Name of the person or firm.

2. Business address and telephone number of person or firm. Include headquarters and local office.

3. Make, model and license number of each vehicle to be used to transport regulated medical waste within the Commonwealth.

4. Name, business address and telephone number of each driver who will operate in the Commonwealth.

5. Areas (counties and cities) of the Commonwealth in which the transporter will operate.

6. a. Any person or firm other than reported in subdivision 1 of this subsection that is associated with the registering firm or any other name under which that person or firm does business.

- b. Any other person or firm using any of the same

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vehicles and operators.

7. The name and phone number of a person who may be contacted in the event of an accident or release.

8. A copy of the signed certification statement as follows:

I, (Full Name of Chief Executive), am chief executive officer of (Legal Name Of Firm) and do here by affirm that all the information provided in this application is correct to the best of my knowledge; and I further affirm that neither this firm, any antecedent firm to this firm, or any of the officers of this or antecedent firms has been convicted of a felony in any state.

C. Within 30 calendar days following the change of any data in subsection B of this section, the transporter shall notify the department of that change. Failure to notify the department nullifies the registration and invalidates the registration number.

D. Use of a false or invalid registration number is prohibited.

Note: All filings of data and requests for registration number and issuance of a registration number shall be in writing.

§ 6.10. Transport by mail.

Transport of regulated medical waste by the United States Postal Services that fully complies with Part 111, (1993) 39 CFR, shall be considered to be transportation by a registered transporter and in compliance with these regulations if:

1. The generator maintains a complete and legible copy of the manifest or mail disposal service shipping record for a period of three years (Note: disposer's certification and other tracking items must be completed and shown on the copy);

2. The addressee is a facility permitted by the all appropriate agencies of the Commonwealth of Virginia or the host state; and

3. No package may be more than 35 pounds by weight.

§ 6.11. Transport using reusable carts or containers.

A. No reusable carts or containers that have been used to manage regulated medical waste may be transported unless they have been cleaned, rinsed and disinfected in a storage facility permitted under these regulations and in compliance with Part V of these regulations.

B. Reusable carts or containers used to transport regulated medical waste must be sealed, highly puncture

resistant, and highly leak resistant. They shall conform in all respects to 49 CFR 172 through 49 CFR 178 for containers and transport of "regulated medical waste."

§ 6.12. Regulated medical waste manifest.

(Reserved)

PART VII.

SPECIAL REQUIREMENTS FOR INCINERATION.

§ 7.1. Application of Part VII.

The requirements of this part apply to all facilities that incinerate regulated medical waste.

§ 7.2. Performance standards.

A. All incinerators for regulated medical waste shall maintain the following level of operational performance at all times:

1. *Operational temperature and retention time.* Whenever regulated medical wastes are incinerated, all the regulated medical waste shall be subjected to a burn temperature of not less than 1400° F. (760° Celsius) for a period not less than one hour. For all incinerators, gases generated by the combustion shall be subjected to a temperature of not less than 1800° F. (982° Celsius) for a period of one second or more. For certain incinerators, gases generated by the combustion shall be subjected to a temperature of not less than 2000° F. (1094° Celsius) for a period of two seconds or more under separate requirements of the State Air Pollution Control Board. Except at start-up, interlocks or other process control devices shall prevent feeding of the incinerator unless these conditions are achieved.

2. *Loading and operating controls.* The incinerator shall have interlocks or other process control devices to prevent feeding of the incinerator until the conditions in subdivision A 1 of this section are achieved. Such devices may have an override for cold start-up. In the event low temperatures occur, facilities shall have automatic auxiliary burners that are capable, excluding the heat content of the wastes, of independently maintaining the secondary chamber temperature at the minimum of 1800° F.

3. *Monitoring.* There shall be continuous monitoring and recording of primary and secondary chamber temperatures. Monitoring data shall be retained for a period of three years.

4. *Waste destruction efficiency.* All combustible regulated medical waste shall be converted by the incineration process into ash that is not recognizable as to its former character.

B. The incinerator shall be permitted under regulations

of the State Air Pollution Control Board and be in compliance with the regulations of that body.

§ 7.3. Analysis and management of the ash product; procedure; results and records; disposition of ash; ash storage.

A. Once every eight hours of operation of a continuously fed incinerator and once every batch or 24 hours of operation of a batch fed incinerator, a representative sample of 250 milliliters of the bottom ash shall be collected from the ash discharge or the ash discharge conveyer. Samples collected during 1000 hours of operation or quarterly, whichever is more often, shall be thoroughly mixed and seven random portions of equal volume shall be composited into one sample for laboratory analysis. This sample shall be tested in accord with the methods established by the Virginia Hazardous Waste Management Regulations for determining if a solid waste is a hazardous waste. Also, the sample shall be tested for total organic carbon content.

At incinerators equipped with air pollution control devices that remove and collect incinerator emissions control ash or dust, this ash shall be held separately and not mixed with bottom ash. Once every eight hours of operation of a continuously fed incinerator and once every batch or 24 hours of operation of a batch fed incinerator, a representative sample of 250 milliliters of the air pollution control ash or dust shall be collected from the pollution control ash discharge. Air pollution control ash or dust samples collected during 1000 hours of operation or quarterly, whichever is more often, shall be thoroughly mixed and seven random portions of equal volume shall be composited into one sample for laboratory analysis. This sample shall be tested in accord with the methods established by the Virginia Hazardous Waste Management Regulations for determining if a waste is a hazardous waste.

B. A log shall document the ash sampling, to include the date and time of each sample collected; the date, time and identification number of each composite sample; and the results of the analyses, including laboratory identification. Results of analyses must be returned from the laboratory and recorded within four weeks following collection of the composite sample. The results and records described in this part shall be maintained for a period of three years, and shall be available for review.

C. If a waste ash is found to be hazardous waste (based on a sample and a confirmation sample) the waste ash shall be disposed of as a hazardous waste in accord with the Virginia Hazardous Waste Management Regulations. If ash is found not to be hazardous waste by analysis, it may be disposed of in a solid waste landfill that is permitted to receive garbage, putrescible waste or incinerator ash, provided the disposal is in accordance with the Solid Waste Management Regulations, VR 672-20-10. If the ash is found to be hazardous waste, the operator shall notify the Director of the Department of

Environmental Quality within 24 hours. No later than 15 calendar days following, the permittee shall submit a plan for treating and disposing of the waste on hand at the facility and all unsatisfactorily treated waste that has left the facility. The permittee may include with the plan a description of the corrective actions to be taken to prevent further unsatisfactory performance. No ash subsequently generated from the incinerator waste stream that was found to be hazardous waste shall be sent to a nonhazardous solid waste management facility in the Commonwealth without the express written approval of the director.

D. Air pollution control ash and bottom ash shall be held separately and not mixed [; however, once both are determined to not be hazardous waste, they may be combined and disposed of as other solid waste] . Throughout the storage of the [ash untested material] it shall be kept in covered highly leak resistant containers. It should be held until the generator determines whether the ash waste is hazardous waste. Areas where [ash untested material] containers are placed must be constructed with a berm to prevent runoff from that area.

E. Regulated medical waste treated in compliance with Part VII, Part VIII or Part IX shall be deemed to be treated in accordance with these regulations. Regulated medical waste not treated in accordance with these regulations shall not be transported, received for transport or disposal, or disposed of in any solid waste management facility.

§ 7.4. Compliance with other parts of these regulations.

In general, incinerator facilities shall comply with all other parts of these regulation. The site of the incinerator facility is a storage facility and must comply with Part V of these regulations. Management of spills or the opening in an emergency of any regulated medical waste package, shall comply with §§ 4.12 and 4.13 of these regulations. Regulated medical wastes that are or will be incinerated in accordance with these regulations are not required to be shredded or ground.

§ 7.5. Unloading operations.

Persons loading and unloading transportation vehicles with regulated medical waste shall wear clean, heavy neoprene gloves (or equivalent) and clean overalls.

§ 7.6. Radiation monitoring.

[Each treatment facility shall establish and maintain a systematic process of monitoring all waste received for the presence of radioactivity above background ambient values. The process shall be capable of detecting any package emitting radiation in excess of background ambient values. When a package is detected that is emitting radiation of more than 30 microrems per hour at the surface of the package, it shall be held in isolation with access controlled. The Nuclear Regulatory

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Commission, the Virginia Department of Health, the Department of Environmental Quality, and the generator shall be notified immediately of each occurrence by the facility operator. Notification shall be by telephone and followed by written notice within five calendar days. No later than 30 calendar days following the date of the telephone notice, the facility operator shall notify the department of the actions taken to resolve the incident and properly manage the packages. (Reserved)]

PART VIII. SPECIAL REQUIREMENTS FOR STEAM STERILIZATION.

§ 8.1. Application of Part VIII.

The requirements of this part apply to all steam sterilizers (autoclaves) that sterilize regulated medical waste.

§ 8.2. Performance standards.

All sterilizers for regulated medical waste shall maintain the following level of operational performance at all times:

1. Operational temperature and detention. Whenever regulated medical wastes are treated in a steam sterilizer, all the regulated medical waste shall be subjected to the following operational standards (at 100% steam conditions and all air evacuated):

a. Temperature of not less than 250° F. for 90 minutes at 15 pounds per square inch of gauge pressure,

b. Temperatures of not less than 272° F. for 45 minutes at 27 pounds per square inch of gauge pressure, or

c. Temperatures of not less than 320° F. for 16 minutes at 80 pounds per square inch of gauge pressure.

*Equivalent combinations of operational temperatures, pressure and time may be approved by the director if the installed equipment has been proved to achieve a reliable and complete kill of all microorganisms in regulated medical waste at design capacity. Written requests for approval of an equivalent standard shall be submitted to the director. Complete and thorough testing shall be fully documented, including tests of the capacity to kill *B. stearothermophilus*. Longer steam sterilization times are required when a load contains a large quantity of liquid.*

2. Operational controls and records.

*a. Steam sterilization units shall be evaluated under full loading for effectiveness with spores of *B. stearothermophilus* no less than once per month.*

b. A log shall be kept at each steam sterilization unit that is complete for the preceding three-year period. The log shall record the date, time and operator of each usage; the type and approximate amount of regulated medical waste treated; the dates and results of calibration; and the results of effective testing described in subdivision 2 a of this section. Where multiple steam sterilization units are used, a working log can be maintained at each unit and such logs periodically consolidated at a central location. The consolidated logs shall be retained for three years and be available for review.

c. Except as described in subdivision 2 b of this section, regulated medical waste shall not be compacted or subjected to violent mechanical stress before steam sterilization; however, after it is fully sterilized it may be compacted in a closed container.

d. Except as provided in § 7.4, § 8.3 E or § 9.3 [E D] , regulated medical waste shall be ground or shredded into particles that are no larger than [0.50 an approximate size of 0.75] inches in any dimension [(this is the statistical mean for each dimension with a 95% confidence limit)] . Grinding or shredding shall occur in a closed unit immediately preceding or following the treatment unit. Transfer from a grinder or shredder to or from a treatment unit shall be [~~automatic and conducted by enclosed mechanical equipment~~ under forced draft ventilation that removes fumes from the operations area to a safe discharge] .

[e. All process units for the preparation or treatment of regulated medical waste shall be in closed vessels under a negative pressure atmospheric control that filters all vents, discharges, and fugitive emissions of air from the process units through a high efficiency particulate air (HEPA) filter with an efficiency of 99.97% of 0.3 microns. Air and gases which have themselves been sterilized by the process are not required to pass through a filter.]

§ 8.3. Disposal of treated wastes.

A. Solid waste that has been steam sterilized and managed in compliance with these regulations is no longer regulated medical waste and is solid waste. Steam sterilized solid waste may be compacted.

B. All [shredded or ground] solid waste that has been steam sterilized shall be placed in opaque plastic bags and sealed. The bags may not be red in color. Where bulk sterilization is used and the solid waste is compacted [and or] immediately placed in closed bulk solid waste management containers, which are more than 64 gallons in volume, the repackaging of the solid waste in bags is not required.

C. [Each bag of steam sterilized solid waste or bulk solid waste container must bear an easily read label, placard, or tag with the following words, "This solid waste has been properly treated in accord with Virginia Regulated Medical Waste Management Regulations and is not regulated medical waste." Regulated medical waste that has been treated must also be ground or shredded in accordance with § 8.2 2 or packaged and labeled in accordance with subsection E of this section.]

D. Regulated medical waste treated in compliance with Part VII, Part VIII or Part IX shall be deemed to be treated in accordance with these regulations. Regulated medical waste not treated in accordance with these regulations shall not be transported, received for transport or disposal, or disposed of in any solid waste management facility.

E. [Steam sterilization facilities in operation on July 1, 1994, and] small scale processes providing treatment in accordance with this part of no more than [five 100] pounds of regulated medical waste per day (monthly average) are not required to shred or grind the waste. [Small scale] Facilities that do not grind or shred the waste must seal the treated waste in an orange plastic bag and securely attach a tag or label with the following message in indelible ink and legible print of a 21-point or greater typeface:

"The generator certifies that this waste has been treated in accordance with the Virginia Regulated Medical Waste Management Regulations and is no longer regulated medical waste.

Treated: (include date treatment performed)

Generator: (include name, address and telephone number of generator) ."

§ 8.4. Compliance with other parts of these regulations.

In general, sterilizer facilities shall comply with all other parts of these regulations. The site of the sterilizer facility is a storage facility and must comply with Part V of these regulations. Management of spills or the opening in an emergency of any regulated medical waste package, shall comply with §§ 4.12 and 4.13 of these regulations.

§ 8.5. Radiation monitoring.

[Each treatment facility shall establish and maintain a systematic process of monitoring all waste received for the presence of radioactivity above background ambient values. The process shall be capable of detecting any package emitting radiation in excess of background ambient values. When a package is detected that is emitting radiation of more than 30 microroms per hour at the surface of the package, it shall be held in isolation with access controlled. The Nuclear Regulatory Commission, the Virginia Department of Health, the Department of Environmental Quality, and the generator shall be notified immediately of each occurrence by the facility operator. Notification shall be by telephone and

followed by written notice within five calendar days. No later than 30 calendar days following the date of the telephone notice, the facility operator shall notify the department of the actions taken to resolve the incident and properly manage the packages. (Reserved)]

PART IX.

SPECIAL REQUIREMENTS FOR ALTERNATIVE TREATMENT.

§ 9.1. Application of Part VIII.

The requirements of this part apply to all alternative treatment methods that treat regulated medical waste.

§ 9.2. Performance standards.

All alternative treatment facilities for regulated medical waste shall maintain the following level of operational performance at all times:

1. Operational controls and records. The following requirements apply to all alternative treatment facilities.

a. Except as provided in § 7.4, § 8.3 E or § 9.3 [E D] , regulated medical waste shall be ground or shredded into particles that are no larger than [0.50 an approximate size of 0.75] inches in any dimension [(this is the statistical mean for each dimension with a 95% confidence limit)] . Grinding or shredding shall occur in a closed unit immediately preceding or following the treatment unit. Transfer from a grinder or shredder to or from a treatment unit shall be [automated and conducted by enclosed mechanical equipment. under forced draft ventilation that removes fumes from the operations area to a safe discharge.]

b. Alternative treatment units shall be evaluated under full loading for effectiveness with spores of *B. stearothermophilus* or *B. subtilis* no less than once per month [(See § 11.8 B)] .

c. A log shall be kept at each alternative treatment unit that is complete for the proceeding three year period. The log shall record the date, time and operator; the type and approximate amount of solid waste treated; and the dates and results of calibration and testing. Where multiple alternative treatment units are used, a working log can be maintained at each unit and such logs periodically consolidated at a central location. The consolidated logs and all performance parameter recordings shall be retained for three years and be available for review.

d. Except as described in [§ 4.15 C and] subdivisions 1 a and 1 e of this section, regulated medical waste shall not be compacted or subjected to violent mechanical stress before treatment. After

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it is fully treated it may be compacted in a closed container [in a safe and sanitary manner] .

e. All process units for the preparation or treatment of regulated medical waste shall be in closed vessels under a negative pressure atmospheric control that filters all vents, discharges, and fugitive emissions of air from the process units through a high efficiency particulate air (HEPA) filter with and efficiency of 99.97% for 0.3 microns.

2. Special requirements by type of treatment. Facilities shall comply with the following treatment requirements for the specific technology employed. [Each treatment unit shall be preceded by grinding or shredding in accordance with subdivision 1 a of this section.]

a. Dry heat treatment.

(1) Any treatment unit employing dry heat as the main treatment process shall subject all the regulated medical waste to:

(a) A temperature of no less than 480° F. for no less than 30 minutes,

(b) A temperature of no less than 390° F. for no less than 38 minutes, or

(c) A temperature of no less than 355° F. for no less than 60 minutes.

(2) No treatment unit employing dry heat as the main treatment process shall have a treatment chamber capacity greater than 1.0 cubic feet in volume.

(3) Each treatment unit shall be equipped to sense, display and continuously record the temperature of the treatment chamber.

b. Microwave treatment.

(1) Microwaving treatment shall incorporate pretreatment by shredding and steam injection or induction.

(2) Any treatment unit employing microwave radiation as the main treatment process shall subject all the solid waste to a temperature of no less than 203° F. for no less than 25 minutes.

(3) Microwave radiation power of the treatment process shall be at least six units each having a power of 1,200 watts or the equivalent power output.

(4) Each microwave treatment unit shall be equipped to sense, display and continuously record the temperature at the start, middle and end of the

treatment chamber.

(5) Process temperatures at the exposure chamber entry and exit the waste flow rate shall be continuously monitored, displayed, and recorded.

c. Chlorination.

(1) Any treatment unit employing chlorination as the main treatment process shall subject all the solid waste to a solution whose initial free residual chlorine concentration is not less than 3,000 milligrams per liter for no less than 25 minutes.

(2) The free chlorine residual of the solid waste slurry after treatment shall be maintained at 200 milligrams per liter. The treated solid waste stream shall be equipped to continuously analyze, display, and record free chlorine residual concentration. [Interval sampling every two minutes or less may be substituted for continuous analysis.]

d. Other alternative treatment technologies. All alternative treatment technologies approved by the director shall conform to the requirements of this part and any additional requirements the director shall impose at the time of approval.

(1) Any person who desires to use a treatment technology other than those described in subdivisions 2 a, 2 b, and 2 c of this section, Part VII or Part VIII shall petition the director for a review under §§ 11.3 and 11.4 of these regulations.

(2) If the director finds that the technology and application is in accord with Article 3 (§ 11.7 et seq.) of Part XI, he may consider the facility for permitting under Part X of these regulations.

(3) The director may issue a public notice that an applicant has demonstrated compliance of a process with §§ 11.8 through 11.12 and consider § 11.13 in a separate review.

§ 9.3. Disposal of treated wastes.

A. Regulated medical waste that has been treated by an alternate treatment technique and managed in compliance with these regulations is no longer regulated medical waste and is solid waste. Treated solid waste may be compacted.

B. All regulated medical waste that has been treated shall be placed in opaque plastic bags and sealed. The bags may not be red in color. Where bulk treatment is used and the solid waste is compacted and immediately placed in closed bulk solid waste management containers, which are more than 64 gallons in volume, the repackaging of the treated solid waste in bags is not required.

[~~C.~~ Each bag of treated solid waste or bulk solid waste container must bear an easily read label, placard, or tag with the following words: "This solid waste has been properly treated in accord with Virginia Regulated Medical Waste Management Regulations and is not regulated medical waste."]

[~~D. C.~~] Regulated medical waste treated in compliance with Part VII, Part VIII or Part IX shall be deemed to be treated in accordance with these regulations. Regulated medical waste not treated in accordance with these regulations shall not be transported, received for transport or disposal, or disposed of in any solid waste management facility.

[~~E. D.~~] Small scale processes providing treatment of no more than five pounds per day (monthly average) of regulated medical waste in accordance with this part are not required to shred or grind the waste. Small scale facilities that do not grind or shred the waste must seal the treated waste in an orange plastic bag and securely attach a tag or label with the following message in indelible ink and legible print of a 21-point or greater typeface:

"The generator certifies that this waste has been treated in accordance with the Virginia Regulated Medical Waste Management Regulations and is no longer regulated medical waste.

Treated: (include date treatment performed)

Generator: (include name, address and telephone number of generator) ."

§ 9.4. Compliance with other parts of these regulations.

In general, alternative treatment facilities shall comply with all other parts of these regulations. The site of the treatment facility is a storage facility and must comply with Part V of these regulations. Management of spills or the opening in an emergency of any regulated medical waste package, shall comply with §§ 4.12 and 4.13 of these regulations.

§ 9.5. Radiation monitoring.

[Each treatment facility shall establish and maintain a systematic process of monitoring all waste received for the presence of radioactivity above background ambient values. The process shall be capable of detecting any package emitting radiation in excess of background ambient values. When a package is detected that is emitting radiation of more than 30 microrems per hour at the surface of the package, it shall be held in isolation with access controlled. The Nuclear Regulatory Commission, the Virginia Department of Health, the Department of Environmental Quality, and the generator shall be notified immediately of each occurrence by the facility operator. Notification shall be by telephone and followed by written notice within five calendar days. No later than 30 calendar days following the date of the telephone notice, the facility operator shall notify the

department of the actions taken to resolve the incident and properly manage the packages. (Reserved)]

PART X. PERMIT APPLICATION AND ISSUANCE PROCEDURES.

§ 10.1. Scope of Part X.

This part of the regulations describes procedures for obtaining a permit for the treatment or storage of regulated medical waste, unless specifically excluded by these regulations or under a permit by rule as defined in §§ 4.1, 4.2, and 4.3 of these regulations. Owners and operators of regulated medical waste management units shall have permits during the active life (including the closure periods) of the unit. The director may issue or deny a permit for one or more units at a facility without simultaneously issuing or denying a permit to all of the units at the facility.

§ 10.2. Applicability; exemptions from permit requirements; [off-site permits by rule;] experimental facility permits; variances.

A. Except for [on-site] permit by rule facilities described in Part IV, no person shall construct, operate or modify a regulated medical waste management facility in this Commonwealth without a permit issued by the director [in accordance with this part] . [Notwithstanding the above, the management of materials excluded under Part III or conditionally exempt under Part III of these regulations shall not require a permit.]

B. Each regulated medical waste management facility permit shall be limited to one site and shall be nontransferable between sites.

C. Issuance of a new permit is required when there is:

1. Any new regulated medical waste management facility; or
2. Any change in design or process of a regulated medical waste management facility that will, in the opinion of the director, result in a substantially different type of facility.

[~~D.~~ Notwithstanding the above, the management of materials excluded under Part III or conditionally exempt under Part III of these regulations shall not require a permit.]

[~~D.~~ Unless the owner or operator of the following facilities chooses to apply for and receive a full permit, he shall be deemed to have a regulated medical waste management facility permit notwithstanding any other provisions of Part X, if all the conditions listed are met:

1. The owner or operator of a storage facility or transfer station:

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- a. Notifies the director of his intent to operate such a facility and provides to the department documentation required under § 10.4 B of these regulations;*
 - b. Provides the director with a certification that the facility meets the standards of Part V;*
 - c. Furnishes to the director a certificate signed by a registered professional engineer that the facility has been designed and constructed in accordance with the standards of Part V;*
 - d. Submits to the director an operational plan describing how the standards of Part V will be met;*
 - e. Submits to the director a closure plan describing how the standards of § 4.14 will be met;*
 - f. Submits to the director the proof of financial responsibility if required by the Financial Assurance Regulations for Solid Waste Facilities (VR 672-20-1); and*
 - g. Submits to the director the results of the public participation effort conducted in accordance with the requirements contained in § 10.2 D 4.*
- 2. The owner or operator of an incineration or other treatment facility:*
- a. Notifies the director of his intent to operate such a facility and provides to the department documentation required under § 10.4 B of these regulations;*
 - b. Provides the director with a certification that the facility meets the standards of Part VII, VIII, or IX;*
 - c. Furnishes to the director a certificate signed by a registered professional engineer that the facility has been designed and constructed in accordance with the standards of Part VII, VIII, or IX;*
 - d. Submits to the director an operational plan describing how the standards of Part VII, VIII, or IX will be met;*
 - e. Submits to the director a closure plan describing how the standards of § 4.14 will be met;*
 - f. Submits to the director the proof of financial responsibility if required by the Financial Assurance Regulations for Solid Waste Facilities (VR 672-20-1); and*
 - g. Furnishes to the director a copy of the facility permit issued for air pollution control of any regulated point source discharges at the facility.*
- 3. Use of materials in a manner constituting disposal.*

(Reserved)

4. Public participation.

a. Before the initiation of any construction at the facility under § 10.2 D 1 or § 10.2 D 2, the owner or operator shall publish a notice in a major local newspaper of general circulation informing the public that he intends to construct and operate a facility eligible for an off-site permit by rule. The notice shall include:

(1) A brief description of the proposed facility;

(2) A statement that the purpose of the public participation is to acquaint the public with the technical aspects of the facility and how the standards and the requirements of these regulations will be met;

(3) Announcement of a 30-day comment period, in accordance with § 10.2 D 4 d, and the name and address of the owner's or operator's representative where comments shall be sent;

(4) Announcement of the date, time, and place for a public meeting held in accordance with § 10.2 D 4 c; and

(5) Location where copies of the documentation to be submitted to the department in support of the off-site permit by rule notification and any supporting documents can be viewed and copied.

b. The owner or operator shall place a copy of the documentation and support documents in a location accessible to the public in the vicinity of the proposed facility.

c. The owner or operator shall hold a public meeting not earlier than 15 days after the publication of the notice required in § 10.2 D 4 a and no later than seven days before the close of the 30-day comment period. The meeting shall be held to the extent practicable in the vicinity of the proposed facility.

d. The public shall be provided 30 days to comment on the technical and the regulatory aspects of the proposal. The comment period will begin on the date the owner or operator publishes the notice in the local newspaper.

5. Upon receiving the certifications and other required documents and after conducting a completeness review, the director will acknowledge their receipt and inform the owner or operator of the status of the submittal. If the applicant's submission is administratively incomplete, the letter will state that the facility will not be considered to have an off-site permit by rule until the missing certifications or other

required documentation is submitted. At the time of the initial receipt or at a later date, the director may require changes in the documents designed to assure compliance with the standards of Parts V, VI, VII, VIII and IX, if applicable. Should such changes not be accomplished by the facility owner or operator, the director may require the operator to submit the full permit application and to obtain a regular regulated medical waste management facility permit.

6. An off-site permit by rule may not be transferred by the permittee to a new owner or operator. However, when the property transfer takes place without proper closure, the new owner shall notify the department of the sale and fulfill all the requirements contained in §§ 10.2 D 1 through 10.2 D 3 with the exception of those dealing with the financial assurance. Upon presentation of the financial assurance proof required by VR 672-20-1 by the new owner, the department will release the old owner from his closure and financial responsibilities and acknowledge existence of the new off-site permit by rule in the name of the new owner.

7. The owner or operator of a facility operating under an off-site permit by rule may modify its design and operation by furnishing the department a new certificate prepared by the professional engineer and a new operational plan. Whenever modifications in the design or operation of the facility affect the provisions of the approved closure plan, the owner or operator shall also submit an amended closure plan. Should there be an increase in the closure costs, the owner or operator shall submit a new proof of financial responsibility as required by the Financial Assurance Regulations for Solid Waste Facilities (VR 672-20-1).

8. In the event that a facility operating under an off-site permit by rule violates any applicable siting, design and construction, or closure provisions of Part V, VII, VIII, or IX, the owner or operator of the facility will be considered to be operating an unpermitted facility and shall be required to either obtain a new permit or close under §§ 4.14, 10.4 and 10.8 of these regulations.

9. The director shall terminate off-site permit by rule and shall require closure of the facility whenever he finds that:

a. As a result of changes in key personnel, the requirements necessary for an off-site permit by rule are no longer satisfied;

b. The applicant has knowingly or willfully misrepresented or failed to disclose a material fact in his disclosure statement, or any other report or certification required under this regulation, or has knowingly or willfully failed to notify the director of any material change to the information in the

disclosure statement; or

c. Any key personnel has been convicted of any of the crimes listed in § 10.1-1409 of the Code of Virginia, punishable as felonies under the laws of the Commonwealth or the equivalent thereof under the laws of any other jurisdiction; or has been adjudged by an administrative agency or a court of competent jurisdiction to have violated the environmental protection laws of the United States, the Commonwealth or any other state and the director determines that such conviction or adjudication is sufficiently probative of the permittee's inability or unwillingness to operate the facility in a lawful manner.]

E. The director may issue an experimental facility permit for any regulated medical waste treatment facility that proposes to utilize an innovative and experimental regulated medical waste treatment technology or process for which permit standards for such experimental activity have not been promulgated under Part VII, Part VIII or Part IX. Any such permit shall include such terms and conditions as will assure protection of human health and the environment. Such permits shall:

1. Provide for the construction of such facilities based on the standards shown in Part V, Part VII, Part VIII, or Part IX, as necessary;

2. Provide for operation of the facility for no longer than one calendar year unless renewed as provided elsewhere in these regulations;

3. Provide for the receipt and treatment by the facility of only those types and quantities of regulated medical waste that the director deems necessary for purposes of determining the efficiency and performance capabilities of the technology or process and the effects of such technology or process on human health and the environment, and

4. Include such requirements as the director deems necessary to protect human health and the environment (including, but not limited to, requirements regarding monitoring, operation, closure and remedial action), and such requirements as the director deems necessary regarding testing and providing of information to the director with respect to the operation of the facility.

For the purpose of expediting review and issuance of permits under this subsection, the director may, consistent with the protection of human health and the environment, modify or waive permit application and permit issuance requirements in Parts V, VII, VIII or IX, except that there may be no modification or waiver of regulations regarding local certification, disclosure statement requirements, financial responsibility (including insurance) or of procedures regarding public participation.

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No experimental permit may be renewed more than three times. Each such renewal shall be for a period of not more than one calendar year.

F. The director may grant a variance from any regulation contained in this part to a permittee provided the requirements of Part X are met.

§ 10.3. Permit conditions.

When issuing a permit, the director may include conditions that he finds necessary to protect public health or the environment or to ensure compliance with these regulations.

§ 10.4. Permit application procedures; notice of intent; Part A application; Part B application; permit issuance.

A. Any person who proposes to establish a new regulated medical waste management facility, or modify an existing regulated medical waste management facility, shall submit a permit application to the department, using the procedures set forth in § 10.2 and other pertinent sections of this part.

B. To initiate the permit application process, any person who proposes to establish a new regulated medical waste management facility ("regulated medical waste management"), or modify an existing regulated medical waste management facility, or to amend an existing permit shall file a notice of intent with the director stating the desired permit or permit amendment, the precise location of the proposed facility, and the intended use of the facility. The notice shall be in letter form and be accompanied by area and site location maps.

No application shall be deemed complete unless it is accompanied by a disclosure statement as shown in Appendix 10.1 for all key personnel.

No application for a permit for a regulated medical waste management facility shall be considered complete unless the notice of intent is accompanied by a certification from the governing body of the county, city, or town in which the facility is to be located stating that the location and operation of the facility are consistent with all applicable ordinances. No certification shall be required for the application for an amendment or modification of an existing permit. For the convenience of the regulated community, a certification form is shown in Appendix 10.2.

If the location and operation of the facility is stated by the local governing body to be consistent with all its ordinances, without qualifications, conditions, or reservations, the applicant will be notified that he may submit his application for a permit. This application shall be submitted in two parts, identified as Part A and Part B.

C. Part A application provides the information essential

for assessment of the site suitability for the proposed facility. It contains information on the proposed facility to be able to determine site suitability for intended uses. It provides information on all siting criteria applicable to the proposed facility.

1. The applicant shall complete, sign and submit three copies of the Part A application containing required information and attachments as specified in § 10.5 to the director.

2. The Part A application will be reviewed for completeness. The applicant will be notified within 15 calendar days whether the application is administratively complete or incomplete. If complete information is not provided within 30 calendar days after the applicant is notified, the application will be returned to the applicant without further review.

3. Upon receipt of a complete Part A application, the department shall conduct a technical review of the submittal. Additional information may be required or the site may be visited before the review is completed. The director shall notify the applicant in writing of approval or disapproval of the Part A application or provide conditions to be made a part of the approval.

4. In case of the approval or conditional approval, the applicant may submit the Part B application providing the required conditions are addressed in the Part B application.

D. The Part B application involves the submission of the detailed engineering design and operating plans for the proposed facility.

1. The applicant, after receiving Part A approval, may submit to the director a Part B application to include the required documentation for the specific regulated medical waste management facility as provided for in § 10.4, 10.5, or 10.6. The Part B application and supporting documentation shall be submitted in three copies. The Part B application must include the required financial assurance documentation. Until the closure plans are approved and a draft permit is being prepared, the applicant must provide evidence of commitment to provide the required financial assurance from a financial institution or insurance company. If financial assurance is not provided within 30 calendar days of notice by the director, the permit shall be denied.

2. The Part B application shall be reviewed for administrative completeness before technical evaluation is initiated. The applicant shall be advised in writing within 30 calendar days whether the application is complete or what additional documentation is required. The Part B application will not be evaluated until a administratively complete application is received.

3. The administratively complete application will be coordinated with other state agencies according to the nature of the facility. The comments received shall be considered in the permit review by the department. The application will be evaluated for technical adequacy and regulatory compliance. In the course of this evaluation, the department may require the applicant to provide additional information. At the end of the evaluation, the department will notify the applicant that the application is technically and regulatorily adequate or that the department intends to deny the application.

4. The procedures addressing the denial are contained in § 10.10.

E. If the application is found to be technically adequate and in full compliance with these regulations, a draft permit shall be developed by the department.

A notice of the availability of the proposed draft permit shall be made in a newspaper with general circulation in the area where the facility is to be located. A informational proceeding will be scheduled and the notice shall be published at least 30 calendar days in advance of the informational proceeding on the draft permit. Copies of the proposed draft permit will be available for viewing at the applicant's place of business or at the regional office of the department upon request in advance of the informational proceeding.

The department shall hold the announced informational proceeding 30 calendar days or more after the notice is published in the local newspaper. The informational proceeding shall be conducted by the department within the local government jurisdiction where the facility is to be located. A comment period shall extend for a 10-day period after the conclusion of the informational proceeding.

A final decision to permit, to deny a permit or to amend the draft permit will be rendered by the director within 30 calendar days of the close of the public comment period.

The permit applicant and the persons who commented during the public participation period shall be notified in writing of the decision on the draft permit. That decision may include denial of the permit (see also § 10.10), issuance of the permit as drafted, or amendment of the draft permit and issuance.

§ 10.5. Part A permit application requirements.

A. The information provided in this section shall be included in the Part A of the permit application for all regulated medical waste management facilities unless otherwise specified in this section.

B. The Part A permit application consists of a letter stating the type of the facility for which the permit

application is made and the certification required in subsection F of this section, the Part A application form shown in Appendix 10.3 with all pertinent information and attachments required by this section.

C. A key map of the Part A permit application, delineating the general location of the proposed facility, shall be prepared and attached as part of the application. The key map shall be plotted on a seven and one-half minute United States Geological Survey topographical quadrangle. The quadrangle shall be the most recent revision available, shall include the name of the quadrangle and shall delineate a minimum of one mile from the perimeter of the proposed facility boundaries. One or more maps may be utilized where necessary to insure clarity of the information submitted.

D. A near-vicinity map shall be prepared and attached as part of the application. The vicinity map shall have a minimum scale of one inch equals 200 feet (1" = 200'). The vicinity map shall delineate an area of 500 feet from the perimeter of the property line of the proposed facility. The vicinity maps may be an enlargement of a United States Geological Survey topographical quadrangle or a recent aerial photograph. The vicinity map shall depict the following:

1. All homes, buildings or structures including the layout of the buildings that will comprise the proposed facility;
2. The boundaries of the proposed facility;
3. The limits of the actual disposal operations within the boundaries of the proposed facility, if applicable;
4. Lots and blocks taken from the tax map for the site of the proposed facility and all contiguous properties;
5. The base flood plain, where it passes through the map area; or, otherwise, a note indicating the expected flood occurrence period for the area;
6. Existing land uses and zoning classification;
7. All water supply wells, springs or intakes, both public and private;
8. All utility lines, pipelines or land based facilities (including mines and wells); and
9. All parks, recreation areas dams, historic areas, wetlands areas, monument areas, cemeteries, wildlife refuges, unique natural areas or similar features.

E. A copy of the lease or deed (showing page and book location) or certification of ownership of the site. The department will not consider an application for a permit from any person who does not demonstrate legal control over the site for the period of the permit life. A

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documentation of an option to purchase will be considered as a temporary substitute for a deed; however, the true deed must be provided to the department before construction at the site begins.

F. A signed statement by the applicant that he has sent written notice to all adjacent property owners or occupants that he intends to develop a regulated medical waste management facility on the site, a copy of the notice and the names and addresses of those to whom the notices were sent.

§ 10.6. Part B permit application requirements.

A. Owners or operators of all regulated medical waste management facilities will use the application procedures of this section. The information provided in this section is required in a Part B permit application.

B. Design plans shall be prepared by a person or firm registered to practice professional engineering in the Commonwealth. The plans shall demonstrate compliance with Parts V, VII, VIII, and IX and include at least the following:

1. Existing site conditions plans sheet indicating site conditions prior to development.
2. Engineering modification plan sheet indicating the appearance of the site after installation of engineering modifications. More than one plan sheet may be required for complicated sites.
3. Phasing plan sheets showing the progression of site development through time. At a minimum, a separate plan shall be provided for initial site preparations and for each subsequent major phase or new area where substantial site preparation must be performed. Each such plan shall include a list of construction items and quantities necessary to prepare the phase indicated.
4. Design drawings of the regulated medical waste management facility to include:
 - a. Profile and plan views of all structures and enclosures showing dimensions. Plan views showing building setbacks, side and rear distances between the proposed structure and other existing or proposed structures, roadways, parking areas and site boundaries;
 - b. Interior floor plans showing the layout, profile view and dimensions of the processing lines, interior unloading, sorting, storage and loading areas as well as other functional areas;
 - c. A plan identifying, locating and describing utilities that will service the facility including, but not limited to, the storm water drainage system, sanitary sewer system, water supply system and

energy system; interface of the proposed facility with the existing utility systems.

5. When applicable, the following information shall be presented on plan sheets:

- a. All information on existing site conditions map unless including this information leads to confusion with the data intended for display.
- b. A survey grid with base lines and monuments to be used for field control.
- c. All drainage patterns and surface water drainage control structures both within the area and at the site perimeter to include berms, ditches, sedimentation basins, pumps, sumps, culverts, pipes, inlets, velocity breaks, sodding, erosion matting, or other methods of erosion control.
- d. Access roads and traffic flow patterns to and within the storage and transfer areas.
- e. All temporary and permanent fencing.
- f. The methods of screening such as berms, vegetation or special fencing.
- g. Wastewater collection, control and treatment systems that may include pipes, manholes, trenches, berms, collection sumps or basins, pumps, and risers.
- h. Special waste handling areas.
- i. Construction notes and references to details.
- j. Other appropriate site features.

6. Detailed drawings and typical sections for, as appropriate, drainage control structures, access roads, fencing, buildings, signs, and other construction details.

C. A design report for the facility is required and will provide the technical details and specifications necessary to support the design plans consisting of, at least, the following information:

1. The introduction to the design report shall identify the project title; engineering consultants; site owner, licensee and operator; site life and capacity; municipalities, industries and collection and transportation agencies served; and waste types to be disposed. It shall also identify any exemptions desired by the applicant.
2. The design capacity specifications shall include, at a minimum, the following information:
 - a. The rated capacity of the facility, in both tons

per day and tons per hour;

b. The expected short-term and projected future long-term daily loadings;

c. The designation of normal loading, unloading and storage areas, including capacities in cubic yards and tons. Description of the time such areas can be practically used, based on expected short-term daily loadings;

d. The designation of emergency loading, unloading, storage or other disposal capabilities to be used when facility system down time exceeds 24 hours;

e. The designation of alternate disposal areas or plans for transfer of stored waste in the event facility system down time exceeds 72 hours;

3. The design specifications for process residues to include the following:

a. The expected daily quantity of waste residue generated;

b. The proposed ultimate disposal location for all facility-generated waste residues including, but not limited to, treated waste, ash residues and by-pass material, residues resulting from air pollution control devices, and the proposed alternate disposal locations for any unauthorized waste types, which may have been unknowingly accepted. The schedule for securing contracts for the disposal of these waste types at the designated locations shall be provided;

c. A descriptive statement of any materials use, reuse, or reclamation activities to be operated in conjunction with the facility, either on the incoming regulated medical waste or the ongoing residue;

4. A descriptive statement and detailed specification of the proposed onsite and off-site transportation system intended to service vehicles hauling waste to the facility for processing, and vehicles removing reclaimed materials and or process residues from the facility. Onsite parking, access and exit points, and the mechanisms or features that will be employed to provide for an even flow of traffic into, out of, and within the site, shall be identified;

5. A detailed analysis shall be made of the financial responsibility for the time of site closing; and

6. An appendix to the design plan shall be submitted and shall include any additional data not previously presented, calculations, material specifications, operating agreements, wastewater treatment agreements, documents related to long-term care funding and other appropriate information.

D. The results of a waste supply analysis program characterizing the quantity and composition of the regulated medical waste in the service area shall be submitted. The waste characterization shall be performed by utilizing a statistically relevant plan that justifies the population sample. The sampling program shall provide for seasonal fluctuations in the quantity and composition of the waste types to be handled at the facility. Anticipated changes in regulated medical waste quantity and composition for each of the waste types to be serviced by the proposed facility shall be projected for that term reflecting anticipated facility life. Within this framework, the effect of existing or future source separation programs on the supply of regulated medical waste within the service area shall be described and quantified. Quantity and compositions analyses shall be carried out simultaneously where possible and shall provide information relating to anticipated maximum, minimum and average daily loading.

E. The operations manual shall provide the detailed procedures by which the operator will implement the design plans and specifications. As a minimum, the operations manual shall include:

1. Daily operations including a discussion of the timetable for development; waste types accepted or excluded; typical waste handling techniques; hours of operation; traffic routing; drainage and erosion control; windy, wet and cold weather operations; fire protection equipment; manpower; methods for handling of any unusual waste types; methods for vector, dust and odor control; daily cleanup; salvaging; record keeping; parking for visitors and employees; monitoring; backup equipment with names and telephone numbers where equipment may be obtained; and other special design features. This information may be developed as a removable section to improve accessibility for the site operator.

2. Site closing information consisting of a discussion of the anticipated sequence of events for site closing and discussion of those actions necessary to prepare the site for long-term care and final use.

3. Long-term care information including a discussion of the procedures to be utilized for the inspection and maintenance of run-off control structures, erosion damage, wastewater control, and other long-term care needs as required by the specific facility design.

F. An emergency contingency plan that delineates procedures for responding to fire, explosions or any unplanned sudden or non-sudden releases of harmful constituents to the air, soil, or surface or ground water shall be submitted to the department as part of the Part B application. Before submission to the department it will be coordinated with the local police and fire departments, and the appropriate health care facility. The contingency plan shall contain:

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1. A description of the actions facility personnel shall take in the event of various emergency situations;

2. A description of arrangements made with the local police and fire department that allow for immediate entry into the facility by their authorized representatives should the need arise, such as in the case of response personnel responding to an emergency situation; and

3. A list of names, addresses and phone numbers (office and home) of all persons qualified to act as an emergency coordinator for the facility. Where more than one person is listed, one shall be named as primary emergency coordinator and the other shall be listed in the order in which they will assume responsibility as alternates.

G. The applicant shall prepare and submit a detailed plan for closing any regulated medical waste management. Such a plan shall be prepared to reflect the actions required at any point in the life of the facility and at the time of closing the facility. The plan should reflect all steps necessary to isolate the facility from the environment or to remove and dispose of all regulated medical waste and residue in the facility. The closure plan should reflect all actions necessary for facility abandonment or uses other than for regulated medical waste management.

§ 10.7. Effect of the permit.

A. A completed permit for a regulated medical waste management facility permit shall be prepared in detail to establish the construction requirements, monitoring requirements, operating limitations or guides, waste limitations if any, and any other details essential to the operation and maintenance of the facility and its closure. Before receipt of waste by the facility, the applicant must:

1. Notify the department, in writing, that construction has been completed; and submit to the department a letter from a professional engineer licensed to practice in the Commonwealth certifying that the facilities have been completed in accordance with the approved plans and specifications and is ready to begin operation.

2. Arrange for a department representative to inspect the site and confirm that the site is ready for operation.

B. Each facility permitted to accept regulated medical waste requires periodic inspection and review of records and reports. Such requirements shall be set forth in the final permit issued by the department. The permit applicant by accepting the permit, agrees to the specified periodic inspections.

C. Compliance with a valid permit and these regulations during its term constitutes compliance for

purposes of enforcement, with the Virginia Waste Management Act. However, a permit may be amended, revoked and reissued, or revoked for cause as set forth in §§ 10.12 and 10.14 of these regulations.

D. The issuance of a permit does not convey any property rights of any sort, or any exclusive privilege.

E. The issuance of a permit does not authorize any injury to persons or property or invasion of other private rights, or any infringement of federal, Commonwealth or local law or regulations.

F. A permit may be transferred by the permittee to a new owner or operator only if the permit has been revoked and reissued, or a minor amendment made to identify the new permittee and incorporate such other requirements as may be necessary.

G. The permit may, when appropriate, specify a schedule of compliance leading to compliance with these regulations.

1. Any schedules of compliance under subsections G or H of this section shall require compliance as soon as possible.

2. Except as otherwise provided, if a permit establishes a schedule of compliance that exceeds one year from the date of permit issuance, the schedule shall set forth interim requirements and the dates for their achievement.

a. The time between interim dates shall not exceed one year;

b. If the time necessary for completion of any interim requirement is more than one year and is not readily divisible into stages of completion, the permit shall specify interim dates for the submission of reports of progress toward completion of the interim requirements and indicate a projected completion date.

3. The permit shall be written to require that no later than 14 calendar days following each interim date and the final date of compliance, a permittee shall notify the director, in writing, of his compliance or noncompliance with the interim or final requirements.

H. A permit applicant or permittee may cease conducting regulated activities (by receiving a terminal volume of regulated medical waste, and, in case of treatment or storage facilities, closing pursuant to applicable requirements, or, in case of disposal facilities, closing and conducting post-closure care pursuant to applicable requirements) rather than continue to operate and meet permit requirements as follows:

1. If the permittee decides to cease conducting regulated activities at a specified time for a permit

that has already been issued:

a. The permit may be amended to contain a new or additional schedule leading to timely cessation of activities; or

b. The permittee shall cease conducting permitted activities before noncompliance with any interim or final compliance schedule requirement already specified in the permit.

2. If the decision to cease conducting regulated activities is made before the issuance of a permit whose terms will include the termination date, the permit shall contain a schedule leading to termination that will ensure timely compliance with applicable requirements.

3. If the permittee is undecided whether to cease conducting regulated activities, the director may issue or amend a permit to continue two schedules as follows:

a. Both schedules shall contain an identical interim deadline requiring a final decision on whether to cease conducting regulated activities no later than a date that ensures sufficient time to comply with applicable requirements in a timely manner if the decision is to continue conducting regulated activities;

b. One schedule shall lead to timely compliance with applicable requirements;

c. The second schedule shall lead to cessation of regulated activities by a date that will ensure timely compliance with applicable requirements.

d. Each permit containing two schedules shall include a requirement that, after the permittee has made a final decision, he shall follow the schedule leading to compliance if the decision is to continue conducting regulated activities, and follow the schedule leading to termination if the decision is to cease conducting regulated activities.

4. The applicant's decisions to cease conducting regulated activities shall be evidenced by a firm public commitment satisfactory to the director, such as a resolution of the board of directors of a corporation.

§ 10.8. Closure care.

A. An owner, operator or permittee intending to close a regulated medical waste management facility shall notify the department of the intention to do so as least 180 calendar days prior to the anticipated date of closing.

B. Closure shall occur in accord with an approved closure plan, which shall be submitted with the permit

application documents and approved with the permit issuance. The holder of the permit shall submit a proposed modified closure plan to the department for review and approval as such modifications become necessary during the life of the facility.

C. The department shall inspect all regulated medical waste management facilities that have been closed to determine if the closing is complete and adequate. It shall notify the owner of a closed facility, in writing, if the closure is satisfactory, and shall order necessary construction or such other steps as may be necessary to bring unsatisfactory sites into compliance with these regulations. Notification by the department that the closure is satisfactory does not relieve the operator of responsibility for corrective action to prevent or abate problems caused by the facility.

§ 10.9. Recording and reporting required of a permittee.

A. A permit may specify:

1. Required monitoring, including type, intervals and frequency, sufficient to yield data that are representative of the monitored activity;

2. Requirements concerning the proper use, maintenance, and installation of monitoring equipment or methods, including biological monitoring methods when appropriate; and

3. Applicable reporting requirements based upon the impact of the regulated activity and as specified in these regulations.

B. A permittee shall be subject to the following whenever monitoring is required by the permit:

1. The permittee shall retain records of all monitoring information, including all calibration and maintenance records and all original strip chart recordings for continuous monitoring instrumentation for at least three years from the sample or measurement date. The director may request that this period be extended.

2. Records of monitoring information shall include:

a. The date, exact place and time of sampling or measurements;

b. The individual(s) who performed the sampling or measurements;

c. The date(s) analyses were performed;

d. The individual(s) who performed the analyses;

e. The analytical techniques or methods used; and

f. The results of such analyses.

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3. Monitoring results shall be maintained on file for inspection by the department.

C. A permittee shall be subject to the following reporting requirements:

1. Written notice of any planned physical alterations to the permitted facility, unless such items were included in the plans and specifications or operating plan approved by the department, shall be given to the director and approved before such alterations are to occur.

2. Reports of compliance or noncompliance with, or any progress reports on, interim and final requirements contained in any compliance schedule of the permit, shall be submitted no later than 14 calendar days following each schedule date.

3. The permittee shall report to the department any noncompliance or unusual condition that may endanger health or environment. Any information shall be provided orally within 24 hours from the time the permittee becomes aware of the circumstances. A written submission shall also be provided within five calendar days of the time the permittee becomes aware of the circumstances. The written submission shall contain a description of the noncompliance and its cause; the period of noncompliance, including exact dates and times, and, if the noncompliance has not been corrected, the anticipated time it is expected to continue. It shall also contain steps taken or planned to reduce, eliminate and prevent reoccurrence of the noncompliance.

4. The permittee shall submit groundwater monitoring reports if required by Part V of these regulations.

D. Copies of all reports required by the permit, and records of all data used to complete the permit application must be retained by the permittee for at least three years from the date of the report or application. The director may request that this period be extended.

E. When the permittee becomes aware that he failed to submit any relevant facts or submitted incorrect information in a permit application or in any report to the director, he shall promptly submit such omitted facts or the correct information with an explanation.

§ 10.10. Permit denial.

A. A permit shall be denied if:

1. The applicant fails to provide complete information required for an application;

2. The facility does not conform with the siting standards set forth for the facility in Part V or Part VI of these regulations unless an exemption or

variance from the specific siting criteria has been granted;

3. The facility design and construction plans or operating plans or both fail to comply with requirements specified for the proposed type of facility unless an exemption or variance from the specific requirement has been granted;

4. The department finds that there is an adverse impact on the public health or the environment by the design, construction or operation will result; or

5. The applicant is not able to fulfill the financial responsibility requirements specified in the Virginia Waste Management Board financial assurance regulations.

B. Reasons for the denial of any permit shall be provided to the applicant in writing by the director.

§ 10.11. Appeal of permit denial.

A. If the department denies a permit to an applicant, the applicant shall be informed in writing of the decision and the reasons supporting the denial decision. The department shall mail the decision to the applicant by certified mail. Within 30 calendar days of the notification date of denial of the permit, the applicant may make a written request of the director for an informational proceeding or hearing to contest the director's decision. The proceeding or hearing shall be conducted in accordance with § 9-6.14:1 et seq. of the Code of Virginia.

B. The director shall render a decision affirming or modifying the previous denial, and shall notify the applicant of his decision in writing. If the director's decision is adverse to the applicant, the applicant may appeal in accordance with § 9-6.14:1 et seq. of the Code of Virginia.

§ 10.12. Revocation or suspension of permits.

A. Any permit issued by the director may be revoked when any of the following conditions exist:

1. The permit holder violates any regulation or order of the board or any condition of a permit where such violation poses a threat of release of harmful substances into the environment or presents a hazard to human health;

2. The regulated medical waste management facility is maintained or operated in such a manner as to constitute an open dump or pose a substantial present or potential hazard to human health or the environment, or the violation is representative of a pattern of serious or repeated violations which, in the opinion of the director, demonstrate the permittee's disregard for or inability to comply with applicable laws, regulations or requirements;

3. The regulated medical waste management facility because of its location, construction or lack of protective construction or measures to prevent pollution, to constitute an open dump or poses a substantial present or potential hazard to human health or the environment;

4. Leachate or residues from the regulated medical waste management facility used for disposal, storage or treatment of regulated medical waste pose a threat of contamination or pollution of the air, surface waters or groundwater;

5. The person to whom the permit was issued abandons, sells, leases or ceases to operate the facility permitted;

6. The owner or operator fails to maintain financial assurance mechanism if required to do so by the Financial Assurance Regulations for Solid Waste Facilities (VR 672-20-1);

7. As a result of changes in key personnel, the director finds that the requirements necessary for issuance of a permit are no longer satisfied;

8. The applicant has knowingly or willfully misrepresented or failed to disclose a material fact in applying for a permit or in his disclosure statement, or any other report or certification required under this law or under the regulations of the board, or has knowingly or willfully failed to notify the director of any material change to the information in the disclosure statement; or

9. Any key personnel has been convicted of any following crimes punishable as felonies under the laws of the Commonwealth or the equivalent thereof under the laws of any other jurisdiction: murder; kidnapping; gambling; robbery; bribery; extortion; criminal usury; arson; burglary; theft and related crimes; forgery and fraudulent practices; fraud in the offering, sale, or purchase of securities; alteration of motor vehicle identification numbers; unlawful manufacture, purchase, use or transfer of firearms; unlawful possession or use of destructive devices or explosives; violation of the Drug Control Act, Chapter 34 (§ 54.1-3400 et seq.) of Title 54.1 of the Code of Virginia; racketeering; or violation of antitrust laws; or has been adjudged by an administrative agency or a court of competent jurisdiction to have violated the environmental protection laws of the United States, the Commonwealth or any other state and the director determines that such conviction or adjudication is sufficiently probative of the applicant's inability or unwillingness to operate the facility in a lawful manner, as to warrant denial, revocation, amendment or suspension of the permit. In making such determination, the director shall consider:

a. The nature and details of the acts attributed to

key personnel;

b. The degree of culpability of the applicant, if any;

c. The applicant's policy or history of discipline of key personnel for such activities;

d. Whether the applicant has substantially complied with all rules, regulations, permits, orders and statutes applicable to the applicant's activities in Virginia;

e. Whether the applicant has implemented formal management controls to minimize and prevent the occurrence of such violations; and

f. Mitigation based upon demonstration of good behavior by the applicant including, without limitation, prompt payment of damages, cooperation with investigations, termination of employment or other relationship with key personnel or other persons responsible for violations or other demonstrations of good behavior by the applicant that the director finds relevant to its decision.

B. If the director finds that regulated medical wastes are no longer being stored, treated or disposed at a facility in accordance with department regulations, the director may revoke the permit issued for such facility and reissue it with a condition requiring the person to whom the permit was issued to provide closure and post-closure care of the facility.

If the director is notified by the permittee that the ownership of the facility will be transferred to a new owner or that the operation will be conducted by a new operator, the director will upon receipt of financial assurance documents required by Financial Assurance Regulations of Solid Waste Facilities (VR 672-20-1), revoke the original permit and reissue it to the new owner or operator.

C. Except in an emergency, a facility posing a substantial threat to public health or the environment, the director may revoke a permit only after a hearing, or a waiver of a hearing, in accordance with § 9-6.14:1 et seq. of the Code of Virginia.

D. If the director summarily suspends a permit pursuant to an emergency based on subdivision 18 of § 10.1-1402 of the Virginia Waste Management Act, the director shall hold a conference pursuant to § 9-6.14:11 of the Virginia Administrative Process Act, within 48 hours to consider whether to continue the suspension pending a hearing to amend or revoke the permit, or to issue any other appropriate order. Notice of the hearing shall be delivered at the conference or sent at the time the permit is suspended. Any person whose permit is suspended by the director shall cease activity for which the permit was issued until the permit is reinstated by the director or by a court.

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§ 10.13. Appeal of a revocation of a permit.

If the director suspends, revokes or revokes and reissues a permit, the permittee may appeal in accordance with § 9-6.14:1 et seq. of the Code of Virginia.

§ 10.14. Amendment of permits.

A. Permits may be amended at the request of any interested person or upon the director's initiative. However, permits may only be amended for the reasons specified in subsections E and F of this section. All requests shall be in writing and shall contain facts or reasons supporting the request.

B. If the director decides the request is not justified, he shall send the requester a brief response giving a reason for the decision.

C. If the director tentatively decides to amend he shall prepare a draft permit incorporating the proposed changes. The director may request additional information and may require the submission of an updated permit application. In a permit amendment under subsection E of this section, only those conditions to be amended shall be reopened when a new draft permit is prepared. All other aspects of the existing permit shall remain in effect. During any amendment proceeding the permittee shall comply with all conditions of the existing permit until the amended permit is issued.

D. When the director receives any information, he may determine whether or not one or more of the causes listed for amendment exist. If cause exists, the director may amend the permit on his own initiative subject to the limitations of subsection E of this section and may request an updated application if necessary. If a permit amendment satisfies the criteria in subsection F of this section for minor amendments, the permit may be amended without a draft permit or public review. Otherwise, a draft permit shall be prepared and other appropriate procedures followed.

E. The director may amend a permit upon his own initiative or at the request of a third party. The director may amend a permit when there is a significant change in the manner and scope of operation which may require new or additional permit conditions or safeguards to protect the public health and environment; there is found to be a possibility of pollution causing significant adverse effects on the air, land, surface water or groundwater; investigation has shown the need for additional equipment, construction, procedures and testing to ensure the protection of the public health and the environment from significant adverse effects; or the amendment is necessary to meet changes in applicable regulatory requirements. Circumstances that may necessitate an amendment include, but are not limited to, the following:

1. When there are material and substantial alterations or additions to the permitted facility or activity that

occurred after permit issuance that justify the application of permit conditions that are different or absent in the existing permit;

2. When there is found to be a possibility of pollution causing significant adverse effects on the air, land, surface water or groundwater;

3. When an investigation has shown the need for additional equipment, construction, procedures and testing to ensure the protection of the public health and the environment from adverse effects;

4. If the director has received information pertaining to circumstances or conditions existing at the time the permit was issued that was not included in the administrative record and would have justified the application of different permit conditions, the permit may be amended accordingly if in the judgment of the director such amendment is necessary to prevent significant adverse effects on public health or the environment;

5. When the standards or regulations on which the permit was based have been changed by promulgation of amended standards or regulations or by judicial decision after the permit was issued;

6. When the director determines good cause exists for amendment of a compliance schedule, such as an act of God, strike, flood, or material shortage or other events over which the permittee has little or no control and for which there is no reasonably available remedy;

7. When an amendment of a closure plan is required and the permittee has failed to submit a permit amendment request within the specified period;

8. When the permittee has filed a request under § 3.6 G of the Financial Assurance Regulations of Solid Waste Facilities (VR 672-20-1) for a variance to the level of financial responsibility or when the director demonstrates under § 3.6 E of those regulations that an upward adjustment of the level of financial responsibility is required; and

9. When cause exists for revocation under § 10.12 and the director determines that an amendment is more appropriate.

F. This subsection provides for permit modification or amendment at the request of the permittee.

1. Minor modifications and permit amendments.

a. Except as provided in subdivisions 1 b and 1 c of this subsection, the permittee may put into effect minor modifications listed in Appendix 10.4 under the following conditions:

(1) The permittee shall notify the director concerning the modification by certified mail or other means that establish proof of delivery at least 14 calendar days before the change is put into effect. This notice shall specify the changes being made to permit conditions or supporting documents referenced by the permit and shall explain why they are necessary. Along with the notice, the permittee shall provide the applicable information required by §§ 10.3 and 10.4, 10.5, or 10.6.

(2) The permittee shall send a notice of the modification to the governing body of the county, city or town in which the facility is located. This notification shall be made within 90 calendar days after the change is put into effect. For the minor modifications that require prior director approval, the notification shall be made within 90 calendar days after the director approves the request.

b. Minor permit modifications identified in Appendix 10.4 by an asterisk may be made only with the prior written approval of the director.

c. In addition to permit modifications listed in Appendix 10.4, the permittee may request the director to approve a modification that will result in a facility that is more protective of the health and environment than these regulations require. The request for such a minor permit modification will be accompanied by a description of the desired change and an explanation of the manner in which the health and environment will be protected in a greater degree than the regulations provide for.

d. For a minor permit modification, the permittee may elect to follow the procedures in subdivision 2 of this subsection for substantive amendments instead of the minor permit modification procedures. The permittee shall inform the director of this decision in the notice required in subdivision 2 of this subsection.

2. Substantive amendments.

a. For substantive modifications, listed in Appendix 10.4, the permittee shall submit a amendment request to the director that:

(1) Describes the exact change to be made to the permit conditions and supporting documents referenced by the permit;

(2) Identifies that the modification is a substantive amendment;

(3) Explains why the amendment is needed;

(4) Provides the applicable information required by §§ 10.3 and 10.4, 10.5, or 10.6; and

(5) Provides the proposed facility mailing list containing the names and addresses of persons, organizations, and agencies of local government that might be affected by the proposed amendment. The director may inform the permittee of additional entries he may require.

b. The permittee shall send a notice of the amendment request to all persons on the facility mailing list and shall publish this notice in a major local newspaper of general circulation. This notice shall be mailed and published within 14 calendar days after the date of submission of the amendment request, and the permittee shall provide to the director evidence of the mailing and publication. The notice shall include:

(1) Announcement of a 60-day comment period, in accordance with subdivision 2 e of this subsection, and the name and address of this department where comments shall be sent;

(2) Announcement of the date, time, and place for a public meeting held in accordance with subdivision 2 d of this subsection;

(3) Name and telephone number of the permittee's contact person;

(4) Name and telephone number of a contact person at the department ;

(5) Location where copies of the amendment request and any supporting documents can be viewed and copied; and

(6) The following statement: "The permittee's compliance history during the life of the permit being modified is available from the Department of Environmental Quality."

c. The permittee shall place a copy of the permit amendment request and support documents in a location accessible to the public in the vicinity of the permitted facility.

d. The permittee shall hold a public meeting not earlier than 30 calendar days after the publication of the notice required in subdivision F 2 b of this subsection and no later than 15 calendar days before the close of the 60-day comment period. The meeting shall be held to the extent practicable in the vicinity of the permitted facility.

e. The public shall be provided 60 calendar days to comment on the amendment request. The comment period will begin on the date the permittee publishes the notice in the local newspaper. Comments should be submitted to the department.

f. Administrative procedure.

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(1) No later than 90 calendar days after receipt of the notification request, the director will determine whether the information submitted under subdivision 2 a (4) of this subsection is adequate to formulate a decision. If found to be inadequate, the permittee will be requested to furnish additional information within 30 calendar days of the request by the director to complete the amendment request record. The 30-day period may be extended at the request of the applicant.

(2) After the completion of the record, the director will:

(a) Approve the amendment request, with or without changes, and modify the permit accordingly;

(b) Deny the request;

(c) Determine that the amendment request shall follow the procedures in subdivision 3 of this subsection for major amendments if (i) the complex nature of the change requires the more extensive procedures for major amendments; or (ii) the department receives notice by the local governing body that the proposed modification requires a determination by that body of consistency with its ordinances; or

(d) Approve the request, with or without changes, as a temporary authorization having a term of up to 180 calendar days in accordance with subdivision 5 of this subsection.

(3) In making a decision to approve or deny a amendment request, including a decision to issue a temporary authorization or to reclassify a amendment as a major, the director will consider all written comments submitted to the department during the public comment period and will respond in writing to all significant comments in his decision.

g. The director may deny or change the terms of a substantive permit amendment request under subdivision 2 f (2) of this subsection for the following reasons:

(1) The amendment request is incomplete;

(2) The requested amendment does not comply with the appropriate requirements of Part V, Part VI, or other applicable requirements; or

(3) The conditions of the amendment fail to protect human health and the environment.

3. Major amendments.

a. For major modifications listed in Appendix 10.4,

the permittee shall submit a amendment request to the director that:

(1) Describes the exact change to be made to the permit conditions and supporting documents referenced by the permit;

(2) Identifies that the modification is a major amendment;

(3) Explains why the amendment is needed;

(4) Provides the applicable information required by §§ 10.3 and 10.4, 10.5, or 10.6; and

(5) Provides the proposed facility mailing list containing the names and addresses of persons, organizations, and agencies of local government. The director may inform the permittee of additional entries he may require.

b. The permittee shall send a notice of the amendment request to all persons on the facility mailing list and shall publish this notice in a major local newspaper of general circulation. This notice shall be mailed and published within 14 calendar days after the date of submission of the amendment request, and the permittee shall provide to the director evidence of the mailing and publication. The notice shall include:

(1) Announcement of a 60-day comment period, in accordance with subdivision F 2 e of this section, and the name and address of this department where comments shall be sent;

(2) Announcement of the date, time, and place for a public meeting held in accordance with subdivision F 2 d of this section;

(3) Name and telephone number of the permittee's contact person;

(4) Name and telephone number of a contact person at the department;

(5) Location where copies of the amendment request and any supporting documents can be viewed and copied; and

(6) The following statement: "The permittee's compliance history during the life of the permit being modified is available from the Department of Environmental Quality."

c. The permittee shall place a copy of the permit amendment request and support documents in a location accessible to the public in the vicinity of the permitted facility.

d. The permittee shall hold a public meeting not

earlier than 30 calendar days after the publication of the notice required in subdivision F 2 b of this section and no later than 15 calendar days before the close of the 60-day comment period. The meeting shall be held to the extent practicable in the vicinity of the permitted facility.

e. The public shall be provided 60 calendar days to comment on the amendment request. The comment period will begin on the date the permittee publishes the notice in the local newspaper. Comments should be submitted to the department.

f. The director shall grant or deny the permit amendment request according to the permit amendment procedures of this section, and other pertinent sections of Part VII.

4. Other amendments.

a. In the case of modifications not explicitly listed in Appendix 10.4, the permittee may submit a major amendment request, or he may request a determination by the director that the modification should be reviewed and approved as a minor or substantive amendment. If the permittee requests that the modification be classified as a minor or a substantive amendment, he shall provide the department with the necessary information to support the requested classification.

b. The director will make the determination described in subdivision F 4 a of this section as promptly as practicable. In determining the appropriate classification for a specific modification, the director will consider the similarity of the modification to other modifications in Appendix 10.4 and the following criteria:

(1) Minor modifications apply to minor changes that keep the permit current with routine changes to the facility or its operation. These changes do not substantially alter the permit conditions or reduce the capacity of the facility to protect human health or the environment. In the case of minor modifications, the director may require prior approval.

(2) Substantive amendments apply to changes that are necessary to enable a permittee to respond, in a timely manner, to:

(a) Common variations in the types and quantities of the wastes managed under the facility permit,

(b) Technological advancements, and

(c) Changes necessary to comply with new regulations, where these changes can be implemented without substantially changing design specifications or management practices in the

permit.

(3) Major amendments substantially alter the facility or its operation.

5. Temporary authorizations.

a. Upon request of the permittee, the director may, without prior public notice and comment, grant the permittee a temporary authorization in accordance with the requirements of subdivision F 5 of this section. Temporary authorizations shall have a term of not more than 180 calendar days.

b. (1) The permittee may request a temporary authorization for:

(a) Any substantive amendment meeting the criteria in subdivision F 5 c (2) (a) of this section, and

(b) Any major amendment that meets the criteria in subdivision F 5 c (2) (a) or F 5 c (2) (b) of this section; or that meets the criteria in subdivisions F 5 c (2) (c) and F 5 c (2) (d) of this section and provides improved management or treatment of a regulated medical waste already listed in the facility permit.

(2) The temporary authorization request shall include:

(a) A description of the activities to be conducted under the temporary authorization;

(b) An explanation of why the temporary authorization is necessary; and

(c) Sufficient information to ensure compliance with Part V or Part VI standards.

(3) The permittee shall send a notice about the temporary authorization request to all persons on the facility mailing list. This notification shall be made within seven calendar days of submission of the authorization request.

c. The director shall approve or deny the temporary authorization as quickly as practical. To issue a temporary authorization, the director shall find:

(1) The authorized activities are in compliance with the standards of Part V, VII, VIII or IX.

(2) The temporary authorization is necessary to achieve one of the following objectives before action is likely to be taken on a amendment request:

(a) To facilitate timely implementation of closure or corrective action activities;

(b) To prevent disruption of ongoing waste

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management activities;

(c) To enable the permittee to respond to sudden changes in the types or quantities of the wastes managed under the facility permit; or

(d) To facilitate other changes to protect human health and the environment.

d. A temporary authorization may be reissued for one additional term of up to 180 calendar days provided that the permittee has requested a substantive or a major permit amendment for the activity covered in the temporary authorization, and (i) the reissued temporary authorization constitutes the director's decision on a substantive permit amendment in accordance with subdivisions F 2 f (2) (d) or F 2 f (3) (d) of this section, or (ii) the director determines that the reissued temporary authorization involving a major permit amendment request is warranted to allow the authorized activities to continue while the amendment procedures of subdivision F 3 of this section are conducted.

6. Appeals of permit amendment decisions. The director's decision to grant or deny a permit amendment request under subsection F of this section may be appealed under the case decision provisions of the Virginia Administrative Process Act.

7. Newly defined or identified wastes. The permittee is authorized to continue to manage wastes defined or identified as regulated medical waste under Part III if he:

a. Was in existence as a regulated medical waste management facility with respect to the newly defined or identified regulated medical waste on the effective date of the final rule defining or identifying the waste; and

b. Is in compliance with the standards of Part V, VII, VIII or IX, as applicable, with respect to the new waste, submits a minor modification request on or before the date on which the waste becomes subject to the new requirements; or

c. Is not in compliance with the standards of Part V or VI, as applicable, with respect to the new waste, but submits a complete permit amendment request within 180 calendar days after the effective date of the definition or identifying the waste.

G. The suitability of the facility location will not be considered at the time of permit amendment unless new information or standards indicate that an endangerment to human health or the environment exists that was unknown at the time of permit issuance.

§ 10.15. Duration of permits.

Any permit for the management of regulated medical waste shall expire after 10 years of operation. Permits shall not be extended beyond the 10 year permit by permit transfer or modifications. At any time more than 180 calendar days prior to the expiration of the permit and no more than 480 calendar days prior to the expiration of the permit, the holder of a valid permit may request that the director renew the permit and submit all information known to permit holder that is changed or new since the original permit application and that has not been previously submitted to the director. A permit may be renewed for a period of 10 years of operation. Processing of the request will be in accordance with the following:

1. If the holder of a valid permit for a regulated medical waste management facility files with the director a request to renew the permit at least 180 calendar days prior to the expiration of that permit, the director will cause an audit to be conducted of the facility's past operation, its current condition and the records held by the department concerning the facility. Within sixty calendar days of receipt of a proper request, the director will report to the applicant the findings of the audit and those items of correction or information required before renewal will be considered. The director shall review the environmental compliance history of the permittee, material changes in key personnel, and technical limitations, standards, or regulations on which the original permit was based. If the director finds repeated material or substantial violations of the permittee or material changes in the permittee's key personnel would make continued operation of the facility not in the best interest of human health or the environment, the director shall deny the request for renewal of the permit. If the director finds the facilities to be insufficient to comply with regulations in effect at the time of the proposed renewal, the director shall deny the request for renewal. The director shall request any information from the permittee that is necessary to conduct the audit, and that is reasonably available to the permittee and substantive to the proposed renewal.

2. If the applicant files for renewal less than 180 calendar days prior to the expiration of the original permit or files an improper application the director shall deny the application for renewal. If an application for renewal has been denied for a facility, any further applications and submittals shall be identical to those for a new facility.

§ 10.16. Existing facilities qualifications.

Owners and operators of existing and permitted infectious waste management facilities are not required to submit an application for a new permit at the time these amended regulations become effective. Existing permits will remain valid, except that conditions or waivers in existing permits that conflict with these amended

regulations are void on the date six months from the effective date of these amended regulations. Operators of existing facilities are required to comply with these amended regulations within six months following their effective date and may comply at any time with any item contained in these regulations in lieu of a conflicting condition contained in an existing permit.

APPENDIX 10.1. DISCLOSURE FORM.

Under § 7(b) of the Privacy Act of 1974, 5 U.S.C. § 552a (note), any government agency that requests an individual to disclose his Social Security Account Number (SSAN) must inform that individual whether the disclosure is mandatory or voluntary, by what statutory or other authority such number is solicited, and what uses will be made of it.

The department is directed to request SSANs by § 10.1-1400 of the Code of Virginia, as specified in the paragraph defining the disclosure statement. The SSAN is used as a secondary identifier by the director when he determines that a criminal records check of the key personnel will be obtained pursuant to subsection D of § 10.1-1405 of the Code of Virginia. The SSAN will then be used to ensure correct identification when information is solicited from outside sources to determine whether the individual named in the records and the individual under consideration are the same or different persons.

The listing of SSANs on the disclosure forms is voluntary. Under Section 7(a) of the Privacy Act, the department cannot deny or revoke a permit or impose any penalty because of an individual's refusal to disclose SSAN. However, the absence of such number as a secondary identifier may delay processing of permit applications because of the additional investigative time that may be necessary to confirm identifications. In addition, there is the possibility that the absence of a SSAN may result in the initial identification of an individual as having a criminal record that actually is that of another person. That, again, may result in delay in the processing of the permit application.

WASTE MANAGEMENT FACILITY PERMIT APPLICANT'S DISCLOSURE STATEMENT

Applicant's Name:

Company Name:

Address:

City: _____ State: _____ Zip: _____
Telephone: (_____) - _____

Applicant's Interest
(Check All Applicable Boxes)

- ☐ Owner
☐ Operator
☐ Other (Explain):

Enter below the names of all key personnel and the starting page number showing more detail.
A separate DEQ Form DISC-02 must be completed for each individual listed below.

Key Personnel	Page	Key Personnel	Page
1.		1.	
2.		2.	
3.		3.	
4.		4.	
5.		5.	
6.		6.	
7.		7.	
8.		8.	
9.		9.	
10.		10.	
11.		11.	
12.		12.	

DEQ Form DISC-01

Page 1 of ____

COVER SHEET

List all agencies outside the Commonwealth which have regulatory responsibility over the applicant or have issued any environmental permit or license to the applicant within the past ten years, in connection with the applicant's collection, transportation, treatment, storage or disposal of solid or hazardous waste.

Agency Name and Permit or License Type	Expiration Date	State

DEQ Form DISC-01

Page 2 of _____

COVER SHEET

List full name and business address of any member of the local governing body or planning commission in which the waste management facility is located or proposed to be licensed, who holds any equity interest in the facility.

Full Name	Business Address

I certify under penalty of the law that the information contained in this disclosure statement and all attachments are, to the best of my knowledge and belief, true, accurate, and complete. I am aware that there are significant penalties for submitting false information, including the possibility of fine and imprisonment for knowing violations.

Signature	Type or Printed Full Name	Title	Date
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DEQ Form DISC-01

Page 3 of ____

COVER SHEET

Continuation from previous pages:

DEQ Form DISC-01

Page 4 of ____

WASTE MANAGEMENT FACILITY PERMIT APPLICANT'S DISCLOSURE STATEMENT	
KEY PERSONNEL	
Name:	
Social Security Name:	
Business Address:	
City: State: Zip:	
List full name and business address of any entity, other than natural persons, that collects, transports, treats, stores, or disposes of solid or hazardous waste in which the	
Company Name	Business Address

DEQ Form DISC-02

Page ___ of ___

Key Personnel	
Business Experience:	
(Use Continuation Sheet, If Needed)	
List all permits or licenses for collection, transportation, treatment, storage, or disposal issued to or held by the person named within the past ten years.	
Full Name	Business Address

DEQ Form DISC-02

Page ___ of ___

Key Personnel

List and explain any notices of violation, prosecution, administrative orders, license or permit suspensions or revocations, or enforcement actions of any sort by any state, federal, or local authority, within the past ten years, which are pending or have concluded with a finding of violation or entry of a consent agreement, regarding an allegation of civil or criminal violation of any law, regulation or requirement relating to the collection, transportation, treatment, storage or disposal of solid or hazardous waste by the person named. Furnish also an itemized list of all convictions with ten years of any of the crimes listed in Section 10.1-1400, Virginia Waste Management Act, punishable as felonies under the laws of the Commonwealth or the equivalent thereof under the laws of any other jurisdiction. Use continuation sheets, if necessary.

DEQ Form DISC-02

Page __ of __

Key Personnel

Continuation Sheet

DEQ Form DISC-02

Page __ of __

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APPENDIX 10.2

REQUEST FOR LOCAL GOVERNMENT

CERTIFICATION

REQUEST FOR CERTIFICATION	
APPLICANT:	
APPLICANT'S MAILING ADDRESS:	DATE OF APPLICATION:
	TELEPHONE:
TYPE OF THE FACILITY:	CONTACT PERSON:

The applicant is in the process of completing an application for a permit for a regulated medical waste management facility to be issued by the Virginia Department of Environmental Quality. In accordance with Section 10.1-1408.1, Title 10.1, Code of Virginia (1950), as amended, before such a permit application can be considered complete, the applicant has to obtain a certification from the governing body of the county, city or town in which the facility is to be located that the location and operation of the facility are consistent with all applicable ordinances. The undersigned requests that an authorized representative of the local governing body sign the certification below.

SIGNATURE OF THE APPLICANT:
TITLE:
NOTE: The applicant should enclose an appropriate map showing the location of the proposed facility.
Certification

The undersigned certifies that the proposed location and operation of the facility is consistent with all ordinances.

SIGNATURE OF THE AUTHORIZED REPRESENTATIVE:	
TYPED OR PRINTED NAME:	
TITLE:	DATE:
COUNTY, CITY OR TOWN:	

DEQ Form CERTIFICATE-01

APPENDIX 10.3

PART A APPLICATION COVER SHEET

PART A APPLICATION COVER SHEET		
NAME OF FACILITY:		
TYPE OF FACILITY:		
NAME OF APPLICANT:		
OWNER (If different from applicant):		
CONTACT PERSON:	PHONE:	
MAILING ADDRESS:		
SITE LOCATION: (Describe location and attach map showing exact location.)		
	YES	NO
KEY MAP ATTACHED?		
NEAR-VICINITY MAP ATTACHED?		
COPY OF DEED or OWNERSHIP DOCUMENT ATTACHED?		
<p>Written notice to adjacent owners or occupants that the undersigned applicant intends to develop a regulated medical waste management facility has been sent. The names and addresses of persons given this notice are shown as an attachment to the form.</p>		
TYPED NAME OF APPLICANT:		
SIGNATURE OF APPLICANT:		

Department of Environmental Quality

DEQ Form PART-1-01

SECTION II - SITING CRITERIA

	YES	NO
SUBJECT TO BASE FLOOD?		
SPRINGS, SEEPS, OR OTHER INTRUSIONS INTO THE SITE?		
PRESENCE OF OPEN DUMP, LANDFILL, LAGOON OR SIMILAR FACILITY?		
PRESENCE OF GAS, WATER, SEWAGE, ELECTRICAL OR OTHER TRANSMISSION LINES ON SITE?		
DISTANCE TO AIRPORT RUNWAY?		
DISTANCE TO REGULARLY FLOWING SURFACE WATER BODY OR RIVER?		
DISTANCE TO WELL, SPRING, OR OTHER GROUNDWATER?		
DISTANCE TO PUBLIC ROAD RIGHT-OF-WAY?		
DISTANCE TO RESIDENCE, SCHOOL, OR RECREATIONAL AREA?		
OTHER CRITERIA APPLICABLE TO THE SITE		

Department of Environmental Quality

DEQ Form PART-1-02

Final Regulations

APPENDIX 10.4. CLASSIFICATION OF PERMIT AMENDMENTS

ModificationsClassification

A. General Permit Provision

1. Administrative and informational changes ... Minor

2. Correction of typographical errors Minor

3. Equipment replacement or upgrading with functionally equivalent components Minor

4. Changes in the frequency of or procedures for monitoring, reporting, sampling by the permittee:

a. To provide for more frequent monitoring, reporting, or sampling, Minor

b. Other changes Substantive

5. Schedule of compliance:

a. Changes in interim compliance dates, with prior approval of the director *Minor

b. Extension of the final compliance date Major

6. Changes in ownership or operational control of a facility *Minor

B. General Facility Standards

1. Changes in procedures in the operating plan

a. That do not affect environmental protection afforded Minor

b. Other changes Major

2. Changes in frequency or content of inspection schedules Substantive

3. Changes in the training plan:

a. That do not affect the type or decrease the amount of training given to employees Minor

b. Other changes Substantive

C. Contingency plan:

1. Changes in emergency procedures (i.e., spill or release response procedures) Substantive

2. Replacement with functionally equivalent equipment, upgrade, or relocate emergency equipment listed
..... Minor

3. Removal of equipment from emergency equipment list Substantive

4. Changes in name, address, or phone number of coordinators or other persons or agencies identified in the plan
..... Minor

D. Closure

1. Changes to the closure plan:

a. Changes in estimate of maximum extent of operations or maximum inventory of waste on-site at any time during the active life of the facility, with prior approval of the director *Minor

b. Changes in the closure schedule for any unit, changes in the final closure schedule for the facility, or extension of the closure period, with prior approval of the director *Minor

c. Changes in the expected year of final closure, where other permit conditions are not changed, with prior approval of the director *Minor

d. Changes in procedures for decontamination of facility equipment or structures, with prior approval of the director *Minor

e. Changes in approved closure plan resulting from unexpected events occurring during partial or final closure, unless otherwise specified in this appendix
..... Substantive

[~~2. Creation of a new landfill unit as part of closure~~
..... ~~Major~~]

[~~3. 2.] Addition of the new storage or treatment units to be used temporarily for closure activities Major~~

E. Post-Closure

1. Changes in name, address, or phone number of contact in post-closure plan Minor

2. Extension of post-closure care period .. Substantive

3. Reduction in the post-closure care period Major

4. Changes to the expected year of final closure, where other permit conditions are not changed
..... Minor

5. Changes in post-closure plan necessitated by events occurring during active life of the facility, including partial and final closure Substantive

I. Incinerators and Energy Recovery Facilities

1. Changes to increase by more than 25% of the waste feed rate limit authorized in the permit . Major

2. Changes to increase by up to 25% any of the waste feed rate limit authorized in the permit Substantive

3. Modification of the facility in a manner that would not likely affect the capability of the unit to meet the regulatory performance standards but which would change the operating conditions or monitoring requirements specified in the permit Substantive

4. Modification of any inspection or recordkeeping requirement specified in the permit Substantive

5. Incineration of different wastes:

a. If the waste contains wastes regulated under Part III not authorized by the permit or if incineration of the waste requires compliance with different regulatory performance standards than specified in the permit. Major

b. If the waste does not contain wastes regulated under Part VIII and if incineration of the waste does not require compliance with different regulatory performance standards than specified in the permit *Minor

J. All Other Facilities

1. Changes to increase by more than 25% of the waste handling capacity authorized in the permit Major

2. Changes to increase by up to 25% of the waste handling capacity authorized in the permit Substantive

3. Modification of the facility in a manner that would not likely affect the capability of the unit to meet the regulatory performance standards but which would change the operating conditions, or monitoring requirements specified in the permit Substantive

4. Modification of any inspection or recordkeeping requirement specified in the permit *Minor

5. Management of different wastes:

a. If the waste contains wastes regulated under Part III not authorized by the permit or if handling of the waste requires compliance with different regulatory performance standards than specified in the permit. Major

b. If the waste does not contain wastes regulated under Part VIII and if handling of the waste does not require compliance with different regulatory performance standards than specified in the permit

..... *Minor

K. Changes in operation of a facility permitted prior to June 30, 1994, when changes reflect compliance with items in these regulations in substitution of similar items or conditions of the existing permit. *Minor

PART XI. VARIANCES AND OTHER PROCEDURES.

Article 1. Petition for Variance.

§ 11.1. General.

Any person directly affected by these regulations may petition the director to grant a variance from any requirement of these regulations, subject to the provisions of this part. Any petition submitted to the director is also subject to the provisions of the Virginia Administrative Process Act (§ 9-6.14:1 et seq. of the Code of Virginia).

The director will not accept any petition relating to:

1. Equivalent testing or analytical methods contained in EPA Publication SW-846;

2. Definitions of regulated medical waste contained in Part III of these regulations; and

3. A change in the regulatory requirements that the petitioner is currently violating until such time as the violation has been resolved through the enforcement process.

Article 2. Variances to Requirements.

§ 11.2. Application and conditions.

The director may grant a variance from any regulation contained in Parts IV through X to a petitioner if the petitioner demonstrates to the satisfaction of the director that:

1. a. Strict application of the regulation to the facility will result in undue hardship that is caused by the petitioner's particular situation, or

b. Technical conditions exist that make a strict application of the regulation difficult to achieve, and

c. The alternate design or operation will result in a facility that is equally protective of the human health and the environment as that provided for in the regulations; and

2. Granting the variance will not result in an unreasonable risk to the public health or the environment.

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§ 11.3. Effects of the decisions.

A. When the director renders a decision under this section in accordance with the procedures contained herein, he may:

1. Deny the petition;
2. Grant the variance as requested; or
3. Grant a modified or partial variance.

B. When a modified variance is granted, the director may:

1. Specify the termination date of the variance;
2. Include a schedule for:
 - a. Compliance, including increments of progress, by the facility with each requirement of the variance; and
 - b. Implementation by the facility of such control measures as the director finds necessary in order that the variance may be granted.

§ 11.4. Submission of petition.

A. All petitions submitted to the director shall include:

1. The petitioner's name and address;
2. A statement of petitioner's interest in the proposed action;
3. A description of desired action and a citation to the regulation from which a variance is requested;
4. A description of need and justification for the proposed action;
5. The duration of the variance, if applicable;
6. The potential impact of the variance on public health or the environment;
7. Other information believed by the petitioner to be pertinent; and
8. The following statements signed by the petitioner or his authorized representative:

"I certify that I have personally examined and am familiar with the information submitted in this petition and all attached documents, and that, based on my inquiry of those individuals immediately responsible for obtaining the information, I believe that the submitted information is true, accurate, and complete. I am aware that there are significant penalties for

submitting false information, including the possibility of fine and imprisonment."

B. In addition to the general information required of all petitioners under this article:

1. To be successful the petitioner shall address the applicable standards and criteria.
2. The petitioner shall provide an explanation of the petitioner's particular situation that prevents the facility from achieving compliance with the cited regulation.
3. The petitioner shall provide other information as may be required by the department.

§ 11.5. Petition processing.

A. After receiving a petition that includes the information required in § 11.4, the director will determine whether the information received is sufficient to render the decision. If the information is deemed to be insufficient, the director will specify additional information needed and request that it be furnished.

B. The petitioner may submit the additional information requested, or may attempt to show that no reasonable basis exists for the request for additional information. If the director agrees that no reasonable basis exists for the request for additional information, he will act in accordance with subsection C of this section. If the director continues to believe that a reasonable basis exists to require the submission of such information, he will proceed with the denial action in accordance with the Virginia Administrative Process Act (VAPA).

C. After the petition is deemed complete:

1. The director will make a tentative decision to grant or deny the petition;
2. In case that petition may be tentatively denied, the director will offer the petitioner the opportunity to withdraw the petition, submit additional information, or request the director to proceed with the evaluation;
3. Unless the petition is withdrawn, the director will issue a draft notice tentatively granting or denying the application. Notification of this tentative decision will be provided by newspaper advertisement in the locality where the petitioner is located. The director will accept comment on the tentative decision for 30 calendar days.
4. Upon a written request of any interested person, the director may, at his discretion, hold an informal fact finding meeting described in Article 3 (§ 9-6.14:11 et seq.) of the Virginia Administrative Process Act. A person requesting a meeting shall state the issues to

be raised and explain why written comments would not suffice to communicate the person's views. The director may in any case decide on his own motion to hold such a meeting.

5. After evaluating all public comments the director will, within 15 calendar days after the expiration of the comment period:

- a. Notify the petitioner of the final decision; and
- b. Notify all persons who commented on the tentative decision or publish it in a newspaper having circulation in the locality.

§ 11.6. Petition resolution.

A. In the case of a denial, the petitioner has a right to request a formal hearing to challenge the rejection.

B. If the director grants a variance request, the notice to the petitioner shall provide that the variance may be terminated upon a finding by the director that the petitioner has failed to comply with any variance requirements.

Article 3. Innovative Treatment Technology Review.

§ 11.7. General.

The requirements for alternate treatment methods contained in Part IX allow, at subdivision 2 d of § 9.2, that new or innovative treatment technologies can be approved for permitting if the director reviews the process and determines that it provides treatment in keeping with these regulations and protects public health and the environment, and if the director establishes appropriate conditions for their siting, design, and operation. This article establishes the criteria, protocols, procedures, and processes to be used to petition the director for review and to demonstrate the suitability of the proposed process for the treatment of regulated medical waste.

§ 11.8. Criteria for microbial inactivation.

A. Inactivation is required to be demonstrated of vegetative bacteria, fungi, all viruses, parasites, and mycobacteria at a 6 Log₁₀ reduction or greater; a 6 Log₁₀ reduction is defined as a 6 decade reduction or a one millionth (0.000001) survival probability in a microbial population (i.e., a 99-99999% reduction).

B. Inactivation is required to be demonstrated of *B. stearothermophilus* spores or *B. subtilis* spores at a 4 Log₁₀ reduction or greater; a 4 Log₁₀ reduction is defined as a 4 decade reduction or a 0.0001 survival probability in a microbial population (i.e., a 99.99% reduction).

§ 11.9. Representative of biological indicators.

A. One or more representative microorganisms from each microbial group shall be used in treatment efficacy evaluation.

1. Vegetative Bacteria.

- *Staphylococcus aureus* (ATCC 6538)
- *Pseudomonas aeruginosa* (ATCC 15442)

2. Fungi.

- *Candida albicans* (ATCC 18804)
- *Penicillium chrysogenum* (ATCC 24791)
- *Aspergillus niger*

3. Viruses.

- Polio 2 or Polio 3
- MS-2 Bacteriophage (ATCC 15597-B1)

4. Parasites.

- *Cryptosporidium* spp. oocysts
- *Giardia* spp. cysts

5. Mycobacteria.

- *Mycobacterium terrae*
- *Mycobacterium phlei*
- *Mycobacterium bovis* (BCG) (ATCC 35743)

B. Spores from one of the following bacterial species shall be used for efficacy evaluation of chemical, thermal, and irradiation treatment systems.

1. *B. stearothermophilus* (ATCC 7953)
2. *B. subtilis* (ATCC 19659)

§ 11.10. Quantification of microbial inactivation.

A. Microbial inactivation ("kill") efficacy is equated to "Log₁₀ Kill," which is defined as the difference between the logarithms of number of viable test microorganisms before and after treatment. This definition is equated as:

$$\text{Log}_{10} \text{ Kill} = \text{Log}_{10} I(\text{cfu/g}) - \text{Log}_{10} R(\text{cfu/g}) \text{ where:}$$

Log₁₀Kill is equivalent to the term Log₁₀ reduction.

"I" is the number of viable test microorganisms introduced into the treatment unit.

"R" is the number of viable test microorganisms

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recovered after treatment.

"cfu/g" are colony forming units per gram of waste solids.

B. For those treatment processes that can maintain the integrity of the biological indicator carrier (i.e., ampules, plastic strips) of the desired microbiological test strain, biological indicators of the required strain and concentration can be used to demonstrate treatment efficacy. Quantification is evaluated by growth or no growth of the cultured biological indicator.

C. For those treatment mechanisms that cannot ensure or provide integrity of the biological indicator (i.e., chemical inactivation/grinding), quantitative measurement of treatment efficacy requires a two step approach: Step 1, "Control"; Step 2, "Test." The purpose of Step 1 is to account for the reduction of test microorganisms due to loss by dilution or physical entrapment.

1. Step 1.

a. Use microbial cultures of a predetermined concentration necessary to ensure a sufficient microbial recovery at the end of this step.

b. Add suspension to a standardized medical waste load that is to be processed under normal operating conditions without the addition of the microbial inactivation agent (i.e., heat, chemicals).

c. Collect and wash waste samples after processing to recover the biological indicator organisms in the sample.

d. Plate recovered microorganism suspensions to quantify microbial recovery. (The number of viable microorganisms recovered serves as a baseline quantity for comparison to the number of recovered microorganisms from wastes processed with the microbial inactivation agent).

e. The required number of recovered viable indicator microorganisms from Step 1 must be equal to or greater than the number of microorganisms required to demonstrate the prescribed Log reduction as specified in § 11.8 (i.e., a 6 Log₁₀ reduction for vegetative microorganisms or a 4 Log₁₀ reduction for bacterial spores). This can be defined by the following equation:

$$\text{Log}_{10}\text{RC} = \text{Log}_{10}\text{IC} - \text{Log}_{10}\text{NR}$$

where: Log₁₀RC is greater than or equal to 6 for vegetative microorganisms and is greater than or equal to 4 for bacterial spores and where:

Log₁₀RC is the number of viable "Control" microorganisms (in colony forming units per gram of waste solids) recovered in the nontreated

processed waste residue.

Log₁₀IC is the number of viable "Control" microorganisms (in colony forming units per gram of waste solids) introduced into the treatment unit.

Log₁₀NR is the number of "Control" microorganisms (in colony forming units per gram of waste solids) that were not recovered after processing. Log₁₀NR represents an accountability fad-or for microbial loss.

2. Step 2.

a. Use microbial cultures of the same concentration as in Step 1.

b. Add suspension to the standardized medical waste load that is to be processed under normal operating conditions with the addition of the microbial inactivation agent.

c. Collect and wash waste samples after processing to recover the biological indicator organisms in the sample.

d. Plate recovered microorganism suspensions to quantify microbial recovery.

e. From data collected from Step 1 and Step 2, the level of microbial inactivation (i.e., "Log₁₀ Kill") is calculated by employing the following equation:

$$\text{Log}_{10}\text{Kill} = \text{Log}_{10}\text{IT} - \text{Log}_{10}\text{NR} - \text{Log}_{10}\text{RT}, \text{ where:}$$

Log₁₀Kill is equivalent to the term Log₁₀ reduction.

Log₁₀IT is the number of viable "Test" microorganisms (in colony forming units per gram of waste solids) introduced into the treatment unit. Log₁₀IT = Log₁₀IC.

Log₁₀NR is the number of "Control microorganisms (in colony forming units per gram of waste solids) that were not recovered after processing.

Log₁₀RT is the number of viable "Test" microorganisms (in colony forming units per gram of waste solids) recovered in treated processed waste residue.

§ 11.11. Efficacy testing protocols.

A. Methodology employed to determine treatment efficacy of the technology will need to assure required microbial inactivation and assure the protocols are congruent with the treatment method. Protocols developed for efficacy testing shall incorporate, as applicable, recognized standard procedures such as those found in Test Methods for Evaluating Solid Waste, Physical/Chemical Methods and Standard Methods for the

Examination of Water and Waste Water.

B. The department shall prescribe those types and compositions of medical wastes that present the most challenge to treatment effectiveness under normal operating conditions of the equipment reviewed.

C. Dependent on the treatment process and treatment efficacy mechanisms utilized, protocols evaluating medical waste treatment systems shall specifically delineate or incorporate, as applicable:

- 1. Waste compositions that typify actual waste to be processed;*
- 2. Waste types that provide a challenge to the treatment process;*
- 3. Comparable conditions to actual use (i.e., process time, temperature, chemical concentration, Ph, humidity, load density, load volume);*
- 4. Assurances that biological indicators (i.e., ampules, strips) are not artificially affected by the treatment process;*
- 5. Assurances of inoculum traceability, purity, viability and concentration;*
- 6. Dilution and neutralization methods that do not affect microorganism viability;*
- 7. Microorganism recovery methodologies that are statistically correct (i.e., sample collection, number of samples/test, number of colony forming units/plate); and*
- 8. Appropriate microbial culturing methods (i.e., avoidance of microbial competition, the selection of proper growth media and incubation times).*

§ 11.12. Technology approval process.

A. To initiate the technology review process the petitioner shall complete and submit the "Petition For Evaluation and Approval of Regulated Medical Waste Treatment Technology Part A: General Information" to the department. The petitioner shall:

- 1. Provide a detailed description of the medical waste treatment equipment to be tested including manufacturer's instructions and equipment specifications, operating procedures and conditions including, as applicable, treatment times, pressure, temperatures, chemical concentrations, irradiation doses, feed rates, and waste load composition;*
- 2. Provide documentation demonstrating the treatment method meets microbial inactivation criteria and required testing protocols including a detailed description of the test procedures and calculations*

used in fulfilling required performance standards verifying treatment efficacy, of user verification methodology, and of microbial culturing protocols that ensure traceability, purity and concentration;

- 3. Provide information on available parametric controls, verifying treatment efficacy and ensuring operator non-interference;*
- 4. Provide documentation of applicable emission controls for suspected emissions;*
- 5. Provide information relating to waste residues including their potential hazards/toxicities and their specific mode of disposal or recycling;*
- 6. Provide documentation providing occupational safety and health assurance; and*
- 7. Provide information on energy efficiency and other potential benefits the treatment technology has to offer to the environment.*

B. The petitioner shall demonstrate that all required surrogate pathogens and resistant bacterial endospores are inactivated to criteria specified in §§ 11.8 and 11.10 under the representative challenge waste load compositions.

C. The petitioner shall develop and demonstrate that site approval and user verification testing protocols are workable and valid.

D. The petitioner shall demonstrate where technically practical, the treatment efficacy relationship between biological indicator data and data procured from real-time parametric treatment monitoring equipment.

E. The petitioner shall demonstrate evidence of U.S. EPA pesticide registration for those treatment processes that employ a chemical agent to inactivate microorganisms.

F. Upon completion of items contained in §§ 11.8 through 11.12, the technology approval that results is granted only under the conditions specified in the manufacturer's instructions and equipment specifications, operating procedures and conditions including, as applicable, treatment times, temperatures, pressure, chemical concentrations, irradiation doses, feed rates, and waste load composition. Any significant revisions to these equipment and operating conditions, as warranted relevant to the department, will require reapplication for approval to the department.

§ 11.13. Site approval process.

A. To fulfill treatment efficacy and information requirements for site approval, the equipment user shall:

- 1. Demonstrate that the equipment cited is the same equipment and process approved by the department*

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as specified in § 11.12.

2. Demonstrate that required resistant bacterial endospores are inactivated as specified in § 11.8 B criteria under typical waste load and department specified challenge compositions;

3. Verify that user verification protocols adequately demonstrate treatment effectiveness; and

4. Verify the treatment efficacy relationship between biological indicator data and data procured from real-time parametric treatment monitoring equipment.

B. The site facility shall provide a written operations plan that includes:

1. The names or positions of the equipment operators;
2. The waste types or categories to be treated;
3. Waste segregation procedures required;
4. Wastes types prohibited for treatment;
5. Equipment operation parameters;
6. Treatment efficacy monitoring procedures;
7. Personal protective equipment requirements;
8. Emergency response plans; and
9. Operator training requirements.

C. The site facility shall submit to the department for their review:

1. Equipment model number and serial number;
2. Equipment specification and operations manual;
3. A copy of the facility's written plan; and
4. Certification documentation of operator training.

D. As a condition of site approval, the department shall have a right to inspect the facility and the right to revoke site approval if health and safety violations are discovered, if permit conditions are not being fulfilled, or if the facility is not adhering to its written plan.

E. Any modifications to the medical waste treatment unit may require re-approval by the director and may involve further efficacy testing.

§ 11.14. User verification.

A. To verify that the medical waste treatment unit is functioning properly and that performance standards are achieved, the petitioner shall:

1. Demonstrate that required resistant bacterial endospores are inactivated to criteria as specified in § 11.8 B under standard operating procedures using protocols that have previously been approved by the department as specified under §§ 11.12 and 11.13.

2. Establish a frequency of biological monitoring; and

3. Document and record all biological indicator and parametric monitoring data.

B. To document treatment efficacy for steam sterilizers and autoclaves, the equipment operator shall:

1. Adopt standard written operating procedures that denote:

- a. Sterilization cycle time, temperature, pressure
- b. Types of waste acceptable
- c. Types of containers and closures acceptable
- d. Loading patterns or quantity limitations;

2. Document times/temperatures for each complete sterilization cycle;

3. Use time-temperature sensitive indicators to visually denote the waste has been decontaminated;

4. Use biological indicators placed in the waste load (or simulated load) periodically to verify conditions meet microbial inactivation requirements as specified in § 11.8 B; and

5. Maintain all records of procedure documentation, time-temperature profiles, and biological indicator results.

§ 11.15. Small medical waste treatment devices.

A. All small medical waste treatment devices shall fulfill the requirements necessary for technology approval and shall meet the treatment efficacy requirements as defined in § 11.8.

B. Technology and siting approval are the responsibility of the petitioner. The petitioner shall provide to the department:

1. All information required for technology approval as defined in § 11.12;

2. All information required of site approval for a typical site for which the equipment is designed as defined in § 11.13; and

3. All materials and documents required of the user to ensure proper use, safety, and effective treatment. These materials and documents would include:

- a. An operations and maintenance manual;
- b. Information on proper use and potential misuse;
- c. Treatment efficacy testing instructions;
- d. Training/education manual; and
- e. Available service agreements/programs.

C. The manufacturer (vendor) shall furnish the user of the treatment device:

1. An operations and maintenance manual;
2. Information on proper use and potential misuse;
3. Treatment efficacy testing instructions;
4. Training/education manual; and
5. Available service agreements/programs.

D. Upon the installation of the treatment device, the manufacturer shall compile a record of the buyer, the location, and the results of onsite challenge testing at time of purchase. This information shall be submitted annually to the department by the petitioner as the notification record of site registrations of equipment installed that previous year.

§ 11.16. Waste residue disposal.

A. Information on the characteristic(s) of all waste residues (liquids and solids), and the mechanism(s) and models) of their disposal shall be provided by the petitioner on the "Evaluation of Medical Waste Treatment Technology: Information Request Form." This information will include:

1. Description of residues (i.e., liquid, solid, shredded, hazardous constituents);
2. Waste designation (i.e. hazardous, special, general);
3. Disposal mechanism (i.e. landfilling, incineration, recycling); and
4. Recycling efforts, if anticipated, (i.e., waste types, amounts, percentages, name and location of recycling effort).

B. Information on waste residue disposal shall be provided by the user facility as required under site approval (§ 11.13). This information shall include:

1. All information requested in § 11.17 A;
2. The site of disposal (name and address);
3. The mechanism of disposal (i.e. landfilling or

incineration); and

4. The amounts of residue(s) anticipated to be disposed (e.g., volume and weight per week).

C. If residue(s) are to be recycled the following information shall be provided by the user facility as required under site approval (§ 11.13). This information shall include:

1. The types of waste residue to be recycled;
2. The amounts of waste residue to be recycled;
3. The percentage of the total waste and waste residue to be recycled;
4. The recycling mechanism used; and
5. The name and location of the recycler.

D. Previously untreated medical wastes used in the development and testing of prototypical equipment shall be considered potentially infectious and will be required to be disposed as untreated medical waste.

E. Prototypical equipment testing using non-infectious or previously treated medical waste (i.e., treated by an approved process such steam sterilization) that has been inoculated with recommended surrogate pathogens can be disposed as general solid wastes after verification of treatment effectiveness.

F. All liquid and solid waste residues will be disposed of in accordance with applicable state and local regulations.

§ 11.17. Operator training.

A. To assure proper operation of the treatment process, the manufacturer (vendor) shall provide to the user as part of the treatment equipment purchase an operator training program that will include:

1. A description of all mechanical equipment, instrumentation, and power controls;
2. A description of system's operations including waste types acceptable, loading parameters, process monitors, treatment conditions, and disposal;
3. A description of all parametric controls, their appropriate settings as correlated with biological indicators, and calibration requirements;
4. A description of proper responses, including identification of system upsets (i.e., power failure, jamming, inadequate treatment conditions) and emergency conditions (i.e., fire, explosion, release of chemical or biohazardous materials);
5. A description of personal protective equipment

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requirements for routine, abnormal, and emergency operations; and

6. A description of all potential occupational safety and health risks posed by the equipment and its use.

B. The facility shall additionally develop a written treatment equipment operations plan that will include:

1. Responsibility delegation for safe and effective equipment operation to operating personnel;

2. A description of operating parameters that must be monitored to ensure effective treatment;

3. A description of all process monitoring instrumentation and established ranges for all operating parameters;

4. A description of the methods required to ensure process monitoring instrumentation is operating properly; and

5. A description of methods and schedules for periodic calibration of process monitoring instrumentation.

C. The facility shall document and keep on record copies of all training for at least three years.

VA.R. Doc. Nos. R94-981 and R94-983; Filed May 11, 1994, 11:43 a.m.

PETITION FOR EVALUATION AND APPROVAL OF
REGULATED MEDICAL WASTE TREATMENT TECHNOLOGY
PART A: GENERAL INFORMATION



Name of Company			
Name of Petitioner (Must be an individual(s) Name)			
Trade Name of Device		Model Number	
Petitioner Address			
City	State	ZIP Code	Petitioner Telephone Number

Department Use Only

Date Application and Questionnaire Received	Date Complete
---	---------------

Note: The review and assessment process will not commence until all information required is submitted by the petitioner and received by the Department.

Treatment Process Petition Page 1

EVALUATION OF MEDICAL WASTE TREATMENT TECHNOLOGY
INFORMATION REQUEST FORM

Complete the following questionnaire and return it along with the application. Please include any additional support data that may be applicable. Use additional paper if necessary. Reference with the related section and number(s).

A. GENERAL

- A1. Is the alternative treatment technology best suited for onsite use at the point of generation, or is it adaptable for use as a commercial or regional treatment process receiving waste from several generators?
- ☐ Onsite ☐ Commercial/Regional ☐ Both
- A2. Is this treatment technology specified for use at small generator facilities such as physician, dental, or veterinary offices or clinics?
- ☐ No ☐ Yes
- A3. Has this alternative treatment technology been approved/disapproved in any other state? If so, please indicate which states have issued a decision and submit copies of approvals/disapprovals.

B. LEVEL OF TREATMENT

- B1. Does the level of microbial inactivation achieved by the treatment process meet the following definition:
- "Inactivation of vegetative bacteria, fungi, all viruses, parasites, and mycobacteria at a 6 Log₁₀ reduction or greater, and *B. stearothermophilus* spores or *B. subtilis* spores at a 4 Log₁₀ reduction or greater."
- ☐ Yes ☐ No - If no, specify where the definition is unfulfilled.

Treatment Process Petition Page 2

C. CHARACTERIZATION OF PROPOSED TREATMENT PROCESS

C1. Please check the appropriate categories that best describe the methods of this proposed technology. Proposed treatment technologies may incorporate several of the categories listed below.

- | | | |
|---|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Chemical | <input type="checkbox"/> Heat | <input type="checkbox"/> Plasma Arc |
| <input type="checkbox"/> Encapsulation | <input type="checkbox"/> Irradiation | <input type="checkbox"/> Radiowave |
| <input type="checkbox"/> Grinder | <input type="checkbox"/> Mechanical | <input type="checkbox"/> Shredder |
| <input type="checkbox"/> Hammermill | <input type="checkbox"/> Microwave | |
| <input type="checkbox"/> Other(specify) _____ | | |

D. WASTE COMPATIBILITY WITH PROPOSED TREATMENT PROCESS

Please identify whether the proposed system is compatible or non-compatible with the following types of waste.

Types of Waste	Compatible	Non-compatible
D1. Cultures and stocks of infectious agents and associated biologicals	<input type="checkbox"/>	<input type="checkbox"/>
D2. Liquid human and animal waste including blood and blood products and body fluids	<input type="checkbox"/>	<input type="checkbox"/>
D3. Pathological Human anatomical waste, tissues and body fluids	<input type="checkbox"/>	<input type="checkbox"/>
D4. Contaminated waste from animals	<input type="checkbox"/>	<input type="checkbox"/>
D5. Sharps	<input type="checkbox"/>	<input type="checkbox"/>

Please refer to the State medical waste regulations for further definition of the medical waste categories and prescribed medical waste management requirements.

D6. What waste characteristics present the most challenge to the proposed treatment process?

- ☐ Organic materials ☐ Liquids ☐ Density/compaction
☐ Other characteristics (Specify) _____

D7. Describe by composition (i.e., material and percentage) those medical wastes that would provide the most challenge to the proposed technology. Why?

E. BY-PRODUCTS OF THE TREATMENT PROCESS

E1. Please indicate all by-products which may be generated as a result of this alternative treatment technology.

- | | | | |
|--|---------------------------------|--------------------------------|--|
| <input type="checkbox"/> Air Emissions | <input type="checkbox"/> Heat | <input type="checkbox"/> Slag | <input type="checkbox"/> Vapors or Fumes |
| <input type="checkbox"/> Ash | <input type="checkbox"/> Liquid | <input type="checkbox"/> Smoke | |
| <input type="checkbox"/> Dust | <input type="checkbox"/> Odor | <input type="checkbox"/> Steam | |
| <input type="checkbox"/> Other (Specify) _____ | | | |

E2. If any of the above by-products are indicated, how will they be controlled?

E3. If there are no by-products indicated, how was this determined?

E4. Are any of these by-products toxic, biohazardous, etc.? ☐ No ☐ Yes
 If yes, explain necessary controls, personal protective equipment, storage, disposal, etc.

F. MICROBIOLOGICAL TEST PROCEDURES

Any proposed treatment method shall be capable of inactivating vegetative bacteria, fungi or yeasts, parasites, viruses, and mycobacteria at a 6 Log₁₀ reduction or greater. Bacterial spores shall be inactivated at a 4 Log₁₀ reduction or greater. A representative from each microbial group is required for testing.

F1. Listed below are several test organisms which have been used as microbiological indicators to determine the effectiveness of a given treatment method. If there are data to support the inactivation of any of the biological indicators using the proposed treatment process under normal operating conditions, please check the appropriate space next to the indicator.

- | | |
|--|--|
| Vegetative Bacteria | Parasites |
| <input type="checkbox"/> <i>Staphylococcus aureus</i> (ATCC 6538) | <input type="checkbox"/> <i>Cryptosporidium</i> spp. oocysts |
| <input type="checkbox"/> <i>Pseudomonas aeruginosa</i> (ATCC 15442) | <input type="checkbox"/> <i>Giardia</i> spp. cysts |
| Fungi | Mycobacteria |
| <input type="checkbox"/> <i>Candida albicans</i> (ATCC 18804) | <input type="checkbox"/> <i>Mycobacterium terrae</i> |
| <input type="checkbox"/> <i>Penicillium chrysogenum</i> (ATCC 24791) | <input type="checkbox"/> <i>Mycobacterium phlei</i> |
| <input type="checkbox"/> <i>Aspergillus niger</i> | <input type="checkbox"/> <i>Mycobacterium bovis</i> (BCG) (ATCC 35743) |
| Viruses | Bacterial Spores |
| <input type="checkbox"/> Polio 2 or Polio 3 | <input type="checkbox"/> <i>B. stearethermophilus</i> (ATCC 7953) |
| <input type="checkbox"/> MS-2 Bacteriophage (ATCC 15597-B1) | <input type="checkbox"/> <i>B. subtilis</i> (ATCC 10659) |

F. MICROBIOLOGICAL TEST PROCEDURES (CONTINUED)

F1. Were the results certified by an independent, public health or certified testing laboratory? ☐ No ☐ Yes - If so, indicate the name, address, telephone number of the certifying laboratory and attach test protocol and results.

G. CHEMICAL INACTIVATION TREATMENT PROCESSES

- G1. If the treatment involves the use of chemical inactivation:
- What is the name of the active ingredients? _____
 - What concentrations must be used and maintained? _____
 - At what Ph is the chemical agent active? _____
 - What is the necessary contact time? _____
 - If there is any incompatibility with specific materials and surfaces, specify. _____
- G2. What is the active life of the chemical agent after it has been exposed to air or contaminated medical waste? _____
- G3. Have studies been conducted relative to the long-term effectiveness of the chemical agent while in use?
☐ No ☐ Yes - If yes, please attach a copy of the study and test results.
- G4. What health and safety hazards may be associated with the chemical (present and long-term)? Specify _____
MSDS Attached? ☐ No ☐ Yes
- G5. Is the chemical agent registered for this specific use with the Environmental Protection Agency (EPA) Pesticide Registration Division?
☐ No ☐ Yes - If yes, provide the EPA registration number _____
- G6. Is the spent chemical agent classified as a hazardous waste by U.S. EPA (40 CFR Part 261) or by other state criteria?
☐ No ☐ Yes - If yes, specify whether by USEPA or which state _____
- G7. Is an environmental impact study for the chemical agent available?
☐ No ☐ Yes - If yes, attach a copy of this information.

H. ENVIRONMENTAL EFFECTS OF THE TREATMENT PROCESS

- H1. Can positive or negative effects on the environment be anticipated from the use and/or disposal of the treated waste from the treatment process?
☐ No ☐ Yes - If yes, specify _____
- H2. What environmental, occupational, and/or public hazards would be associated with a malfunction of the treatment process? Specify _____
- H3. If the treatment process includes the use of water, steam, or other liquids; how will this waste discharge be handled (i.e., sewer, recycle, etc.)? Specify _____
- H4. How will the treated waste from this process be disposed of (i.e., landfill, incineration, recycle, etc.)? Specify _____
- H5. Are the by-products identified as a hazardous waste?
☐ No ☐ Yes - Complete item M1

I. CRITICAL FACTORS OF TREATMENT PROCESS

- I1. What are the critical factors that influence the specific treatment technology? Specify _____
- I2. What are the consequences if these factors are not met? Specify _____
- I3. Explain the ease and/or difficulty of operation of the medical waste treatment system? Specify _____
- I4. What type of ongoing maintenance is required in the operation of the treatment system? Specify _____
Maintenance Manual Attached? ☐ No ☐ Yes
- I5. What emergency measures would be required in the event of a malfunction? Specify _____
- I6. Are these measures addressed in an emergency plan or in the operations protocol?
☐ No ☐ Yes - If yes, attach a copy
- I7. What is the maximum amount of waste to be treated by this process per cycle? _____
- I8. How long is a cycle? _____

J. QUALITY ASSURANCE AND VERIFICATION OF ADEQUATE TREATMENT

- J1. How is the quality assurance of the treatment process addressed?
Specify _____
- J2. What is the recommended frequency that a microbiological indicator should be used to confirm effectiveness of the system?
Specify _____
- J3. Other than the biological indicators listed in Section F, what other indicators, integrators, or monitoring devices would be used to show that the treatment unit or process was functioning properly? (Please describe and explain.)

- J4. How is it determined that the processed waste has received proper treatment? (Check the appropriate item.)
- Temperature indicator: ☐ Visual only ☐ Continuous ☐ Both
- Pressure indicator: ☐ Visual only ☐ Continuous ☐ Both
- Time indicator: ☐ Visual only ☐ Continuous ☐ Both
- Chemical concentration indicator: ☐ Visual only ☐ Continuous ☐ Both
- ☐ Other - Please specify _____
- J5. Have the treatment process monitors been correlated with biological indicators to ensure effective and accurate monitoring of the treatment process?
Specify _____
- J6. Is there a process monitor calibration schedule established, and at what frequency is calibration performed?

- J7. Are the process monitors interfaced to the system's operations to effect proper treatment conditions? Explain.

- J8. Are the process monitor controls secured to prevent operator over-ride of the process before treatment is adequately effected? Explain.

K. POST TREATMENT RECYCLING

- K1. Has a strategy been developed for the recycling of any part of the treated waste? ☐ No ☐ Yes If yes, please include additional information regarding the strategy.

L. COMPLIANCE WITH STATE MEDICAL WASTE REGULATIONS

- L1. Does your treatment technology meet the requirements of the State's medical waste regulations for medical waste decontamination and disposal?
☐ No ☐ Yes
- L2. Which of the following five categories of medical waste will be effectively treated by your system? (Check all that apply.)
- | | NO | YES |
|--|--------------------------|--------------------------|
| a) Cultures and Stocks | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Blood and Blood Products and Body Fluids | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Pathological Human Anatomical Waste,
Human Tissues and Body Fluids | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Sharps | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Contaminated Animal Wastes | <input type="checkbox"/> | <input type="checkbox"/> |

M. INTERAGENCY COORDINATION

- M1. Have you inquired from the State's medical waste permit coordinator as to whether any other permits are required? ☐ No ☐ Yes
If yes, please enclose the response and requirements with your application.

NOTE: Local governments may require permits.

N. POTENTIAL ENVIRONMENTAL BENEFITS

- N1. Has an energy analysis been conducted on the proposed technology?
☐ No ☐ Yes - If yes, specify and provide results of that analysis.
- N2. Has an economic analysis been performed on the proposed technology?
☐ No ☐ Yes - If yes, specify and provide results of that analysis.
- N3. How does this treatment technology improve on existing medical waste treatment and disposal methods?
 Specify _____
- N4. What is the potential of this proposed technology for:
 Wastevolumereduction? Specify _____
 Recycling? Specify _____

O. OTHER RELEVANT INFORMATION AND COMMENTS

(Approvals received from other states, operator safety, competency or training requirements for the users/operators, etc.)

PETITION FOR EVALUATION AND APPROVAL OF
REGULATED MEDICAL WASTE TREATMENT TECHNOLOGY
PART B: ATTACHMENTS

The general information contained in Part A and this check sheet are a required part of the petition package. These assist the petitioner in submitting the petition and the Department in its review, and they are supplemental to the required documents listed below. The complete petition package consists of a completed Part A form, this Part B check sheet, all the documents listed below, and any other supportive data or information the petitioner wishes to be considered.

- ☐ Petitioner's submittal certification
- ☐ Quality Assurance and Quality Control Report
- ☐ Microbiological testing report
- ☐ Material Safety Data Sheets
- ☐ Environmental Protection Agency pesticide registration documents
- ☐ Maintenance manual
- ☐ Emergency operations manual
- ☐ Operations manual
- ☐ Design plans and specifications

STATE CORPORATION COMMISSION

AT RICHMOND, APRIL 27, 1994

COMMONWEALTH OF VIRGINIA, ex rel.

STATE CORPORATION COMMISSION

CASE NO. PUE940030

Ex Parte, In re: Consideration of standards for integrated resource planning and investments in conservation and demand management for natural gas utilities

ORDER FOR NOTICE AND HEARING

The 102nd Congress of the United States adopted the Energy Policy Act of 1992, P.L. 102-486, 106 Stat. 2803 ("the Act") on October 24, 1992. Section 115 of the Act adds additional provisions to Section 303, 16 U.S.C. § 3203, of the Public Utility Regulatory Policies Act of 1978 ("PURPA"). Among other things, these provisions require that within two years of the enactment of the Energy Policy Act of 1992, State utility regulatory authorities, including the State Corporation Commission ("Commission"), provide public notice and conduct a hearing regarding integrated resource planning for gas utilities and investments by gas utilities in conservation and demand management. Section 303, 16 U.S.C. § 3203(a)(2), also requires the Commission to consider whether adoption of these standards "is appropriate to carry out the purpose of this title [of PURPA], is otherwise appropriate, and is consistent with otherwise applicable State law." The Act further requires that if the State regulatory authority implements a standard established by Subsection (b)(3) or (4) of 15 U.S.C. § 3203(b), "it must consider the impact that implementation of such standard would have on small businesses engaged in the design, sale, supply, installation, or servicing of energy conservation, energy efficiency, or other demand-side management measures, and . . . implement such standard so as to assure that utility actions would not provide such utilities with unfair competitive advantages over such small businesses." The Commission must conclude its investigation of these standards no later than October 24, 1994.

Accordingly, by this Order we initiate an investigation to consider whether the standards set out in Section 115 of the Act or any portions thereof should be adopted. In furtherance of this investigation, we invite comments and testimony from interested parties on the standards and related issues set out in Appendix A hereto.

Interested parties may also address any other issues of concern to them regarding these standards. Further, we will direct our Staff to summarize and evaluate the comments and testimony received herein and file its analysis thereof, together with any recommendations with the Commission. A public hearing will be convened to take evidence on the recommendations set forth in the Staff's

analysis and on the testimony received from interested parties. Interested persons who do not intend to appear at the hearing may file comments with the Clerk of the Commission regarding the issues identified herein.

Accordingly, IT IS ORDERED:

(1) That this matter shall be docketed and assigned Case No. PUE940030;

(2) That on or before May 5, 1994, each natural gas public utility subject to the Commission's jurisdiction shall make a copy of this Order, together with the appendices thereto, available for public inspection during regular business hours at all of its business offices where customer bills may be paid. These utilities shall likewise make a copy of the Staff's analysis available for public inspection when it is filed. On or before May 5, 1994, the Commission's Document Control Center shall make a copy of this Order available for public review in its offices, located on the first floor of the Tyler Building, 1300 East Main Street, Richmond, Virginia, during its regular business hours;

(3) That a public hearing shall be convened on September 7, 1994, at 10:00 a.m. in the Commission's Courtroom, located on the second floor of the Tyler Building, 1300 East Main Street, Richmond, Virginia to receive evidence relevant to the adoption of the standards for natural gas utilities and the issues identified herein;

(4) That on or before June 15, 1994, any interested party who does not plan to attend the public hearing scheduled herein but who desires to participate in this proceeding may file with the Clerk of the Commission an original and five (5) copies of comments concerning the standards for natural gas utilities and issues identified herein, as well as any other issues of concern to that party regarding the standards for natural gas utilities under consideration. All comments shall refer to Case No. PUE940030 and shall be addressed to William J. Bridge, Clerk of the State Corporation Commission, c/o Document Control Center, P.O. Box 2118, Richmond, Virginia 23216;

(5) That on or before June 15, 1994, any interested party who intends to participate in the public hearing may file with the Clerk of the Commission at the address set forth above an original and fifteen (15) copies of the direct testimony and exhibits the party intends to present at the hearing scheduled herein. Said testimony and exhibits shall address the standards for natural gas utilities and issues identified herein, together with any other issues of concern to the party. Any party's testimony and accompanying exhibits shall refer to Case No. PUE940030, and each interested party filing testimony shall, upon request, provide a copy of his testimony to any other party requesting a copy of same;

(6) That on or before July 20, 1994, the Staff shall file with the Clerk of the Commission an original and fifteen (15) copies of its analysis of the testimony submitted by

interested parties and its recommendations as either a report or as testimony and supporting exhibits. The Staff's analysis shall include a summary and an evaluation of the comments received pursuant to Ordering Paragraph (4) hereof. A copy of the Staff's analysis shall be served on all parties filing testimony and upon any person filing comments requesting a copy of same;

(7) That any person desiring to make a statement at the public hearing concerning the natural gas standards and issues identified herein need only appear in the Commission's Second Floor Courtroom at 9:30 a.m. on the day of the hearing and identify himself or herself to the Bailiff as a public witness;

(8) That on or before August 15, 1994, any interested person filing direct testimony shall file with the Clerk of the Commission an original and fifteen (15) copies of all testimony it expects to introduce in rebuttal to all comments and direct prefiled testimony and exhibits of any interested party and to the Staff's filed analysis. Additional rebuttal evidence may be presented by interested parties filing testimony, provided it is in response to evidence which was not prefiled but elicited at the time of the hearing, and provided further the need for additional rebuttal evidence is timely addressed by motion during the hearing and leave to present said evidence is granted. Parties shall serve a copy of their prefiled rebuttal evidence upon all parties prefiling direct testimony;

(9) That on or before May 13, 1994, the Commission's Division of Economics and Finance shall complete publication of the following notice on one occasion as classified advertising, to be published in major Virginia newspapers of general circulation throughout the Commonwealth of Virginia:

NOTICE TO THE PUBLIC OF THE INVESTIGATION
OF THE STATE CORPORATION COMMISSION
INTO STANDARDS FOR NATURAL GAS PUBLIC
UTILITIES ESTABLISHED BY SECTION 115 OF
THE ENERGY POLICY ACT OF 1992 - CASE NO.
PUE940030

On October 24, 1992, the Energy Policy Act of 1992 was enacted by the United States Congress. Among the provisions of that Act is a requirement that the State Corporation Commission ("Commission") provide public notice and conduct a hearing on the standards set out in Section 115 of the Energy Policy Act of 1992 governing integrated resource planning and conservation and demand management for natural gas utilities.

The Commission has initiated the captioned investigation to receive evidence regarding the standards specified in § 115 of the Energy Policy Act of 1992 for natural gas utilities and has scheduled a public hearing for September 7, 1994, at 10:00 a.m. in its courtroom located on the second

floor of the Tyler Building, 1300 East Main Street, Richmond, Virginia, for the purpose of receiving evidence relevant to its investigation.

On or before June 15, 1994, any interested person may file with the Clerk of the Commission at the address set forth below an original and fifteen (15) copies of testimony and accompanying exhibits: William J. Bridge, Clerk of the Commission, c/o Document Control Center, P.O. Box 2118, Richmond, Virginia 23216. This testimony should address the standards and issues identified in the Commission's Order for Notice and Hearing entered in this case and should refer to Case No. PUE940030.

Interested persons desiring to participate in the investigation who do not plan to attend the hearing may participate by filing an original and five (5) copies of comments on or before June 15, 1994, addressing the issues identified in the Commission's Order for Notice and Hearing with the Clerk of the Commission at the address set forth above.

The Commission's Order for Notice and Hearing governs the procedure in this case. This Order also identifies the standards specified in the Energy Policy Act of 1992 under investigation and the issues which the Commission has directed interested parties filing comments or testimony to address. A copy of this Order may be obtained by writing to the Clerk of the Commission, c/o Document Control Center, P.O. Box 2118, Richmond, Virginia 23216, and referring to Case No. PUE940030. A copy of this Order is also available for public review in the Commission's Document Control Center, located on the first floor of the Tyler Building, 1300 East Main Street, Richmond, Virginia, during its regular business hours of 8:15 a.m. to 5:00 p.m., Monday through Friday. Copies of the Commission's Order for Notice and Hearing are also available for public review at the business offices where customer bills may be paid of all natural gas public utilities subject to the Commission's jurisdiction. Interested persons should review this Order for the details of the procedural schedule, issues to be addressed in testimony or comments, and instructions on how to participate in this proceeding.

VIRGINIA STATE CORPORATION COMMISSION
DIVISION OF ECONOMICS AND FINANCE

(10) That the Division of Economics and Finance shall forthwith send a copy of this Order, together with its appendices to the Virginia Register for publication; and

(11) That on or before August 29, 1994, the Division of Economics and Finance shall file with the Clerk of the Commission proof of publication of the notice prescribed herein.

AN ATTESTED COPY hereof shall be sent by the Clerk

State Corporation Commission

of the Commission to: all natural gas public utilities subject to the Commission's jurisdiction set forth in Appendix B hereto; all electric public utilities subject to the Commission's jurisdiction set forth in Appendix C hereto; all electric cooperatives subject to the Commission's jurisdiction set forth in Appendix D; the parties set out in Appendix E hereto; and the Commission's Office of General Counsel and Divisions of Energy Regulation and Economics and Finance.

APPENDIX A

PURPA STANDARDS AND RELATED ISSUES

I.

INTEGRATED RESOURCE PLANNING STANDARD

Integrated resource planning. Each gas utility shall employ [an integrated resource plan] (sic), in order to provide adequate and reliable service to its gas customers at the lowest system cost. All plans or filings of a State regulated gas utility before a State regulatory authority to meet the requirements of this paragraph shall (A) be updated on a regular basis, (B) provide the opportunity for public participation and comment, (C) provide for methods of validating predicted performance, and (D) contain a requirement that the plan be implemented after approval of the State regulatory authority. Subsection (c) shall not apply to this paragraph to the extent that it could be construed to require the State regulatory authority to extend the record of a State proceeding in submitting reports to the Federal Government.

15 U.S.C. § 3203(b)(3).

ISSUES CONCERNING INTEGRATED RESOURCE PLANNING

1. Should the Integrated Resource Planning ("IRP") standard in Section 115 be adopted by the Commission? Why or why not?
2. Should the IRP standard in Section 115 be modified and adopted by the Commission? If so, what modifications should be made?
3. How does the IRP standard promote the PURPA Title III objectives of:
 - a. the conservation of energy supplied by gas utilities,
 - b. optimization of the efficient use of facilities and resources by gas utility systems and
 - c. equitable rates to natural gas customers?
4. What incremental benefits would implementation of an IRP process for gas utilities in Virginia provide to

natural gas utility ratepayers?

- a. What elements or requirements must be contained in the IRP process to produce these benefits?
- b. How could the IRP process be managed in a timely and efficient manner?
- c. What would be the consequences of not implementing an IRP process?

5. Would IRP require the Commission to take a more proactive role in utility resource decisions than it has traditionally?

a. If so, does this usurp the management responsibilities of utility executives?

b. Should reduced utility responsibility be quantified in the development of utility rates?

6. Would an increased assumption of what has traditionally been viewed as management's prerogative by the Commission be consistent with the Commission's statutory responsibilities and authority?

7. Does the increased responsibility for procuring natural gas supplies associated with the implementation of FERC Order No. 636 dictate Commission adoption of a formal review and approval of IRP plans for natural gas utilities?

8. Planning is a management process to minimize risks and recognize opportunities in an environment of complex interwoven dynamic systems. Such an environment dictates that effective planning continue to evolve to recognize continuous and ever-changing factors. How can an IRP process which implies or refers to the implementation of a completed final product be reconciled with this basic planning tenet?

9. Would an IRP process represent increased regulation which could conflict with a movement toward increased competition among and between energy suppliers and substitute energy service providers?

10. What is an appropriate time frame for requiring: (a) the implementation of approved IRP plans, (b) the full planning period, (c) the lead time needed for the next capacity related gas acquisition decision, or for plans that must be implemented prior to the next scheduled planning submittal?

11. Does the requirement of public participation in the IRP process require public hearings or can public participation be achieved through other means?

12. How can the time constraints imposed by public participation and comment in a formal review of integrated resource plans and a requirement that such

plans be implemented be reconciled with the changing nature of load projections, gas price forecasts, and the need for quick decisions often associated with FERC pipeline filings and settlement proceedings?

13. Will the requirement that approved IRP plans be implemented expose utility consumers and stockholders to unnecessary gas price forecast uncertainty?

14. Given the uncertainties that are inherent in any forecast of the price of gas, does the proposed IRP standard present barriers and risks that cannot be overcome?

15. For multi-jurisdictional utilities, would the adoption of the IRP standard result in the potential for contradictory requirements from the various jurisdictions or requirements for the implementation of incompatible IRP plans?

16. How should "life cycle costs" referred to in the definition of "integrated resource planning," 15 U.S.C. § 3202(9), be defined?

17. What does the phrase "validating predicted performance" mean? Should this clause be modified?

18. Is the objective "to minimize life cycle costs" included in the definition of "integrated resource planning," 15 U.S.C. § 3202(9), always consistent with the objective to provide reliable service "at the lowest system cost" included in the standard?

II.

CONSERVATION AND DEMAND MANAGEMENT STANDARD

Investments in conservation and demand management. The rates charged by any State regulated gas utility shall be such that the utility's prudent investments in, and expenditures for, energy conservation and load shifting programs and for other demand-side management measures which are consistent with the findings and purposes of the Energy Policy Act of 1992 are at least as profitable (taking into account the income lost due to reduced sales resulting from such programs) as prudent investments in, and expenditures for, the acquisition or construction of supplies and facilities. This objective requires that (A) regulators link the utility's net revenues, at least in part, to the utility's performance in implementing cost-effective programs promoted by this section; and (B) regulators ensure that, for purposes of recovering fixed costs, including its authorized return, the utility's performance is not affected by reductions in retail sales volumes.

15 U.S.C. § 3203(b)(4).

ISSUES REGARDING CONSERVATION AND DEMAND

MANAGEMENT

1. Should the Investments in Conservation and Demand Management standard be adopted by the Commission? Why or why not?

2. Should the Investments in Conservation and Demand Management standard in Section 115 be modified and adopted by the Commission? If so, what modifications should be made?

3. How does the Investments in Conservation and Demand Management standard promote the PURPA Title III objectives of:

a. the conservation of energy supplied by gas utilities,

b. optimization of the efficient use of facilities and resources by gas utility systems and

c. equitable rates to natural gas customers?

4. Section 115 of the Energy Policy Act of 1992 appears to impose more stringent standards on gas utilities than the comparable Section 111 requirement for electric utilities in that it imposes additional provisions that "(A) regulators link the utility's net revenues, at least in part, to the utility's performance in implementing cost-effective [conservation and load management] programs... and (B) regulators ensure that, for purposes of recovering fixed costs, including its authorized return, the utility's performance is not affected by reductions in its retail sales volumes." What are the implications of a more stringent standard for gas utilities?

5. Section 115 of the Energy Policy Act of 1992 indicates that the Commission should consider adopting standards which, among other things, would require ratemaking treatment that assures that investments and expenditures in demand side measures be at least as profitable, giving consideration to lost revenues, as supply side initiatives.

a. Would the adoption of such a standard preclude the use of the "ratepayer impact measure" ("RIM") adopted in Case No. PUE900070 for evaluating conservation and load management ("CLM") programs?

b. Or alternatively, does this provision require the use of the ratepayer impact measure ("RIM") test described in the Commission's June 28, 1992 Order Issuing Rules on Cost/Benefit Measures, entered in Commonwealth of Virginia, ex rel. State Corporation Commission, Ex Parte, In re: Investigation of conservation and load management programs, Case No. PUE900070, since lost revenues must be considered and such losses are by implication a cost to the utility?

6. Does the standard requiring that demand-side management ("DSM") investments and expenditures be at least as profitable as supply side alternatives require the approval of a deferral mechanism for "lost revenues" or are the Commission's existing ratemaking practices acceptable in that the recovery of both demand and supply side costs are subject to regulatory lag?

7. Are supply-side expenditures associated with the purchase of natural gas given preferential treatment relative to demand side measures since these supply-side costs are recovered pursuant to an automatic adjustment clause?

8. Do DSM related "lost revenues" satisfy the Commission's traditional test for automatic adjustment clauses?

a. Specifically, do "lost revenues" represent a volatile cost?

b. Is this cost beyond a utility's control?

c. Will these costs have a significant impact on the utility's financial viability?

d. If the conditions surrounding "lost revenues" do not satisfy the Commission's historic test for automatic adjustment clauses, should the test be modified?

9. Does the term "demand side management" as defined in Section 115 of the Energy Policy Act of 1992 include the encouragement of transportation services, interruptible services, fuel switching, etc.?

10. Are utility funded CLM incentives workable given increased competition between the electric and gas industries?

11. Should the adoption of an equal treatment standard for CLM measures be predicated on a Commission finding that market barriers are deterring ratepayers from making cost effective investments in energy conservation?

12. Are the Section 115 standards appropriate in the absence of market barriers to cost effective end-use conservation measures?

13. What does the term "profitable" in the Investments in Conservation and Demand Management standard mean? What should it mean?

14. What does it mean to "link the utility's net revenues, at least in part, to the utility's performance in implementing cost-effective programs"? Would such a linking promote the goals of PURPA?

15. How can regulators ensure that the utility's

"performance is not affected by reductions in its retail sales volumes"?

III.

SMALL BUSINESS IMPACT FINDING

Small business impacts. If a State regulatory authority implements a standard established by Subsection (b)(3) or (4), such authority shall—

(1) consider the impact that implementation of such standard would have on small businesses engaged in the design, sale, supply, installation, or servicing of energy conservation, energy efficiency, or other demand-side management measures, and

(2) implement such standard so as to assure that utility actions would not provide such utilities with unfair competitive advantages over such small businesses.

15 U.S.C. § 3203(d).

ISSUES REGARDING SMALL BUSINESS IMPACT FINDING

1. What constitutes a "small business" pursuant to Section 115 of the Energy Policy Act of 1992?

2. What is the Commission's statutory authority to consider the impact of IRP standards on small businesses and to assure that the adoption of such standards do not provide utilities with an unfair competitive advantage?

3. Are non-utility providers of competing fuels "engaged in the design, sale, supply, installation, or servicing of energy conservation, energy efficiency, or other demand side measures"?

4. What constitutes an "unfair competitive advantage" with respect to the impact of IRP standards on small businesses?

5. What issues should the Commission consider when evaluating the impacts of IRP standards on "small businesses"?

IV.

OTHER ISSUES REGARDING AMENDMENTS TO PURPA

1. Should the definition of "integrated resource planning" in Section 115 be modified?

2. Should the same standards be applied to each gas utility?

3. Are the two Section 115 standards consistent with

other objectives and policies of this Commission?

Appendix B

Gas Companies in Virginia

Commonwealth Gas Services, Inc.
Mr. Thomas E. Harris, President
800 Moorefield Park Drive
P.O. Box 35800
Richmond, Virginia 23236-3659

Commonwealth Public Service Corp.
Mr. R. E. Painter, Manager
P.O. Box 589
Bluefield, West Virginia 24701

Roanoke Gas Company
Mr. Frank A. Farmer, Jr., President
P.O. Box 13007
Roanoke, Virginia 24011

Shenandoah Gas Company
Mr. Kenneth G. Behrens, General Manager
P.O. Box 2400
Winchester, Virginia 22601

Southwestern Virginia Gas Company
Mr. Allan McClain, President
P.O. Drawer 5391
Martinsville, Virginia 24115

United Cities Gas Company
Mr. Gene Koonce, President & General Manager
5300 Maryland Way
Brentwood, Tennessee 37027

Virginia Natural Gas
Mr. W. F. Fritsche, Jr., President & CEO
5100 East Virginia Beach Blvd.
Norfolk, Virginia 23502

Virginia Gas Distribution Company
Mr. Michael L. Edwards, President
120 South Court Street
Abingdon, Virginia 24210

Washington Gas Light Company
Mr. Jeremiah K. Hughitt, President
1100 H. Street, N.W.
Washington, D.C. 20005

Appendix C

Electric Companies in Virginia

Appalachian Power Company
Mr. Joseph H. Vipperman, President
Post Office Box 2021
Roanoke, VA 24022-2121

Delmarva Power & Light Company
Mr. R. Erik Hansen
General Manager Pricing and Regulation
800 King Street
Post Office Box 231
Wilmington, Delaware 19899

Kentucky Utilities Company
Mr. Robert M. Hewett
Vice President, Rates
Budget & Financial Forecasts
One Quality Street
Lexington, Kentucky 40507

The Potomac Edison Company
Mr. Alan J. Noia, President
Downsville Pike
Hagerstown, Maryland 21740

Virginia Electric and Power Company
Mr. Edgar M. Roach, Jr.
Vice President - Regulation
Box 26666
Richmond, VA 23261

Appendix D

Electric Cooperatives in Virginia

A&N Electric Cooperative
Mr. Vernon N. Brinkley
Executive Vice President
P.O. Box 1128
Parksley, Virginia 23421

B-A-R-C Electric Cooperative
Mr. Hugh M. Landes
General Manager
P.O. Box 264
Millboro, Virginia 24460-0264

Central Virginia Electric Cooperative
Mr. Howard L. Scarboro
General Manager
P.O. Box 247
Lovingston, Virginia 22949

Community Electric Cooperative
Mr. J. M. Reynolds
General Manager
Post Office Box 267
Windsor, Virginia 23487

Craig-Botetourt Electric Cooperative
Mr. Gerald H. Groseclose
General Manager
Post Office Box 265
New Castle, VA 24127

Mecklenburg Electric Cooperative
Mr. John Bowman

State Corporation Commission

General Manager
Caller 2451
Chase City, Virginia 23924-2451

Northern Neck Electric Cooperative
Mr. Charles R. Rice, Jr.
General Manager
Post Office Box 288
Warsaw, Virginia 22572-0288

Northern Virginia Electric Cooperative
Mr. Stanley C. Feuerberg
General Manager
Post Office Box 2710
Manassas, VA 22110

Powell Valley Electric Cooperative
Mr. Randell W. Meyers
General Manager
Post Office Box 308
Church Street
Jonesville, VA 24263

Prince George Electric Cooperative
Mr. Gene G. Carr
General Manager
Post Office Box 168
Waverly, VA 23890

Rappahannock Electric Cooperative
Mr. Cecil E. Viverette, Jr.
President
Post Office Box 7388
Fredericksburg, VA 22404-7388

Shenandoah Valley Electric Cooperative
Mr. C. D. Wine
Executive Vice President
Post Office Box 236
Route 257
Mt. Crawford, VA 22841-0236

Southside Electric Cooperative
Mr. John C. Anderson
Executive Vice President
Post Office Box 7
Crewe, VA 23930

PARTIES

Allied-Signal, Inc.
Edward R. Pruitt
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Morristown, New Jersey 07960

American Lung Association of Virginia
Stephen M. Ayres, M.D.
P.O. Box 7065
Richmond, Virginia 23221-0065

Anheuser-Busch Companies, Inc.
Gary Foster
One Busch Place
St. Louis, Missouri 63118

Apartment & Office Building Association
Frann G. Francis, Esquire
1050 17th Street, N.W., Suite 300
Washington, D.C. 20036

Appomattox Cogeneration, Ltd.
Hopewell Cogeneration, L.P.
Wythe Park Power
Enron-Richmond Power Corporation
Cogentrix of Virginia Leasing
Mark J. LaFratta, Esquire
McGuire, Woods, Battle & Boothe
One James Center
Richmond, Virginia 23219-4030

Browning-Ferris Gas Services
Philip F. Abraham
P.O. Box 788
Richmond, Virginia 23206

CRSS Capital, Inc.
Timothy R. Dunne, Esquire
P.O. Box 22477
Houston, Texas 77227-2427

Celanese Fibers, Inc.
Robert Gribben
Narrows, Virginia 24124

Chesapeake-Westvaco Corporation
Virginia Hydro Power Association
Chesapeake Paper Products Company
c/o Edward L. Flippen, Esquire
Mays & Valentine
P.O. Box 1122
Richmond, Virginia 23208-1122

City of Richmond
David B. Kearney, Esquire
900 East Broad Street
Suite 300
Richmond, Virginia 23219

APPENDIX E

Cogentrix, Inc.
T. Randolph Perkins, Esquire
9405 Arrow Point Boulevard
Charlotte, North Carolina 28217

Corning Glass Works
Hooker W. Horton, Purchasing Manager - Energy
HP-ME-1-10
Corning, New York 14831

Dan River Mills
K. W. Parrish, Director of Engineering and Utilities
P.O. Box 261

Danville, Virginia 24523

Department of Energy
Lawrence A. Gollomp
Assistant General Counsel for Regulatory Interventions and
Power Marketing
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Du Pont/Conoco
Steven A. Huhman
Coordinator-Regulatory Affairs
CH1002
P.O. Box 2197
Houston, Texas 77252

Fairfax County Board of Supervisors
Dennis R. Bates, Esquire
1200 Government Center Parkway, Suite 549
Fairfax, Virginia 22035

Ford Motor Company
F.C. Corley, P.E.,
Energy Efficiency and Supply Department
15201 Century Drive, Suite 602 CPN
Dearborn, Michigan 48120

Owens-Brockway Glass Container, Inc.
John Wesolowski
One Seagate
Toledo, Ohio 43604

Griffin Pipe Products Co.
John Keenan
Director - Purchasing and Traffic
1400 Opus Place, Suite 700
Downers Grove, Illinois 60515-5700

Hershey Foods
Don A. Hornung, Energy Affairs Officer
19 East Chocolate Avenue
Hershey, Pennsylvania 17033-0819

Home Builders Association of Virginia
Eric M. Page, Esquire
316 West Broad Street
Richmond, Virginia 23220

ICI Americas, Inc.
Rod Davies, Energy Specialist
Corporate Purchasing
Delaware Corporate Center One
Wilmington, Delaware 19897

Intermet Corporation
L. E. Glass
Corporate Energy Department
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Lynchburg, Virginia 24505

International Business Machines Corporation

David M. Karle, Advisory Engineer
9500 Godwin Drive
Manassas, Virginia 22110

Kenworth E. Lion, Esquire
1306 Turnmill Drive
Richmond, Virginia 23235

Metro Machine Corporation
Charles Garland
Imperial Docks
P.O. Box 1860
Norfolk, Virginia 23501

Nabisco Brands, Inc.
Henry Riewerts
100 DeForest Avenue
P.O. Box 1911
East Hanover, New Jersey 07936

National Independent Energy Producers
c/o Karen A. Tomcala, Esquire
Latham & Watkins
1001 Pennsylvania Avenue, N.W., Suite 1300
Washington, D.C. 20004-2505

Natural Resources Defense Council
Daniel Lashof
1350 New York Avenue, N.W.
Washington, D.C. 20005

Office of the Attorney General
Division of Consumer Counsel
Edward L. Petrini, Esquire
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Richmond, Virginia 23219

Old Dominion Committee for Fair Utility Rates
Virginia Committee for Fair Utility Rates
Bear Island Paper Company
Virginia Gas Users Association
Louis R. Monacell, Esquire
1200 Mutual Building
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Old Dominion Electric Cooperative
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President and Chief Executive Officer
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Piedmont Environmental Council
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State Corporation Commission

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Richmond, Virginia 23219

Reynolds Metals Company
Kenneth A. Berry, Esquire
Law Department, EXO-21
P.O. Box 27003
Richmond, Virginia 23261

Rock-Tenn Company
Al Smith
P.O. Box 4098
Norcorss, Georgia 30091

Rural Virginia, Inc.
Richard D. Cagan, Registered Agent
P.O. Box 9081
Petersburg, Virginia 23906

Sierra Club-Virginia Chapter
William B. Grant, Chair, Energy Conservation Subcommittee
803 Marlbank Drive
Yorktown, Virginia 23692-4353

Southern Environmental Law Center
Oliver A. Pollard, III, Esquire
Jeffrey M. Gleason, Esquire
201 West Main Street, Suite 14
Charlottesville, Virginia 22902

Sycom Enterprise
S. Lynne Sutcliffe
7475 Wisconsin Avenue, 6th Floor
Bethesda, Maryland 20814

Transphase Systems, Inc.
Douglas A. Ames, President
8000 Midlantic Drive, Suite 201 South
Mt. Laurel, New Jersey 08054-5080

Union Camp Corporation
Edward C. Minor, Associate General Counsel
Route 58 East
Franklin, Virginia 23851-0178

Virginia Association of Non-Utility Power Producers
Attention: August Wallmeyer, Executive Director
700 East Franklin Street, Suite 701
Richmond, Virginia 23219

Virginia Citizens Consumer Council
Jean Ann Fox, President
114 Coachman Drive
Yorktown, Virginia 23693

Virginia Cogen
David C. Pace
P.O. Box 34652

Richmond, Virginia 23234

Virginia-Maryland-Delaware Association
Charles C. Jones, Jr., Executive Vice President
4201 Dominion Boulevard, Suite 200
Glen Allen, Virginia 23060

Virginia Citizen Action
1531 West Main Street, 2nd Floor
Richmond, Virginia 23220

Virginia Cooperative Extension Service
VPI and State University
Lori Marsh, Assistant Professor and Extension Agricultural Engineer
Blacksburg, Virginia 24061-0512

Virginia Council Trout Unlimited
DuBose Egleston, Jr., Chairman
P.O. Box 838
Waynesboro, Virginia 22980

Virginia Wildlife Federation
Neal D. Emerald
5915 Grisby House Court
Centreville, Virginia 22020

Westvaco Corporation
c/o John J. Carrara, Esquire
299 Park Avenue
New York, New York 10171

V.A.R. Doc. No. R94-958; Filed May 6, 1994, 4:33 p.m.

* * * * *

Title of Regulation: Securities Act Rules (Rules 300, 404, 504 and 507)

Statutory Authority: § 12.1-13 of the Code of Virginia.

Summary:

The VIRGINIA STATE CORPORATION COMMISSION will consider adopting proposed changes to its SECURITIES ACT RULES. The proposed changes are summarized as follows:

Rule 300 (Notice of Civil, Criminal or Administrative Action): Add to the list of reportable events specified in paragraph A 1 language requiring notification to the Commission of any arbitration action against a registrant related to broker-dealer or agent activities; add new provisions permitting a registrant to notify the Commission either directly (as is now required) or indirectly via the NASAA/NASD Central Registration Depository system; delete the existing provisions of paragraph B requiring the filing of a copy of each document related to any action against the registrant and add new paragraph C requiring such filings upon

request of the Commission; and make changes to clarify provisions of the Rule.

Rule 404 (Renewal Applications Filed by Investment Companies): Add provisions permitting registration renewals relating to investment company securities to be effected through the Securities Registration Depository, when it becomes available.

Rule 504 (NASDAQ/NMS Exemption): The NASD has filed a petition requesting the Commission to amend this exemption to include initial public offerings listed on the NASDAQ/NMS. The proposed Rule change appended to the petition incorporates broader modifications - it also exempts a security that is senior to or of equal rank to a listed security as well as warrants or rights to purchase such securities and deletes the listing and some of the other criteria enumerated in the existing Rule. The adoption of the NASD proposal would, in effect, repeal existing Rule 504. The NASD may file on or about May 13, 1994, one or more changes to its proposed Rule that would (i) modify the provision concerning the Commission's authority to withdraw the exemption; (ii) require the issuer to file with the Commission notice of use of the exemption; and (iii) impose investor suitability standards in connection with high-risk initial public offerings.

Rule 507: New rule to create a security registration exemption for soliciting indications of interest in receiving a prospectus for a security to be registered (so called "test-the-waters" exemption), proposed in accordance with the 1994 amendment of Va. Code § 13.1-514.1.

Copies of these proposals are available from the Commission's Division of Securities and Retail Franchising, P.O. Box 1197, Richmond, VA 23209, (804) 371-9187, FAX (804) 371-9911. Written comments are invited. Any interested person who files objections to the proposed changes will, if so requested, be afforded an opportunity to present evidence and be heard. Comments and requests should be sent to the Commission's Document Control Center, P.O. Box 2118, Richmond, VA 23216. Documents filed with respect to Rule 504 must be received by June 13, 1994, and should refer to Case No. SEC940031. Documents filed with respect to Rule 300, 404 or 507 must be received by June 24, 1994, and should refer to Case No. SEC940048. Interested persons who file objections and request to be heard, or who ask to be informed, will be notified of the date, time and place of the hearing.

ARTICLE III BROKER-DEALER AND AGENT REGULATIONS

Rule 300 Notice of Civil, Criminal, or Administrative or Arbitrational Action

A. An applicant or a registrant shall notify the

Commission:

1. Within thirty (30) calendar days of the date a any complaint, pleading or notice is served or received giving notice of any civil, criminal or administrative charges charge or any arbitration proceeding or a any formal order of investigation, including any such charge, proceeding or order by a self-regulatory organization registered under the Securities Exchange Act of 1934, against the applicant or registrant which directly or indirectly relates to the registration or sale of securities, or which directly or indirectly relates to the applicant's or registrant's activities any activity as a broker-dealer or agent or to any other activity in which a breach of trust is alleged.

2. Within thirty (30) calendar days of the date filed, any answer, reply or response to any the complaint, pleading or notice filed as outlined referred to in subsection A.1., above.

3. Within thirty (30) calendar days of the date of any decision, order or sanction rendered, or any appeal filed with respect to such decision, order or sanction, in regard to any the complaint, pleading or notice outlined in referred to in subsection A.1., above.

B. One (1) copy of such complaint, answer or reply, decision, order, or sanction shall be filed with the Commission at the time of notification in accordance with A.1., A.2. and A.3. of this Rule. A registrant who is a NASD member broker-dealer or is associated with a NASD member broker-dealer may file the notification required by section A. of this Rule either with the Commission's Division of Securities and Retail Franchising or on and in compliance with all requirements of the NASAA/NASD Central Registration Depository system.

C. One (1) copy of any item referred to in subsection A.1, A.2. or A.3., above, shall be filed with the Commission promptly following a request for same.

Rule 404 Requirements for Renewal Applications Filed Pursuant to Code Section 13.1-512

In accordance with Section 13.1-512 of the Act, a registration statement and any renewal thereof relating to a security issued by a face-amount certificate company or a redeemable security issued by an open-end management company as those terms are defined in the Investment Company Act of 1940, shall expire at midnight on the annual date of its effectiveness in Virginia. The effectiveness of such registration statement may be renewed for an additional one year period by filing the following materials described below with the Commission or the Securities Registration Depository, Inc. ("SRD"), when that facility is available, prior to the expiration date.

A. A renewal application filed with the Commission shall

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contain the following:

1. A facing page of Form U-1.
2. A fee of \$300.00 (make check payable to Treasurer of Virginia).

B. A renewal application filed with the SRD shall be filed on and in compliance with all requirements and forms prescribed by the SRD and shall include a fee of \$300.00 (make check payable to SRD).

Note: Refer to Rule 700 for prospectus filing requirements.

Rule 504 NASDAQ/National Market Exemption

In accordance with Section 13.1-514 A 12, the following are exempt from the securities registration requirements of the Act: any security listed or approved for listing upon notice of issuance on the National Association of Securities Dealers Automated Quotation National Market (NASDAQ/National Market); any other security of the same issuer that is of senior or substantially equal rank; any security called for by subscription rights or warrants so listed or approved; or any warrant or right to purchase or subscribe to any of the foregoing. The Commission may withdraw the exemption by order if it determines that the NASDAQ/National Market requirements are so changed from those set forth in the Memorandum of Understanding (published in Securities Act Release No. 33-6810,53 Federal Register 52550, Dec. 28, 1988), as amended, or insufficiently applied that the public interest and protection of investors contemplated by the requirements are no longer afforded.

Rule 504 NASDAQ/National Market System Exemption

In accordance with Section 13.1-514 A.12: of the Act, any security designated on the National Association of Securities Dealers Automated Quotations National Market System (NASDAQ/National Market System) is exempt from the securities registration requirements of the Act if (i) the issuer of the security meets any of the criteria set forth in Section A and (ii) the system has at least the following criteria set forth in Sections B through F:

A. The issuer, or in the case of an American Depositary Receipt, the foreign issuer of the underlying equity securities, has been subject to the reporting requirements of Section 13 of the Securities Exchange Act of 1934 for the preceding 180 days; or,

in the case of an insurance company meeting the conditions of Section 12(g)(2)(G) of the Securities Exchange Act of 1934, such company has been subject to the reporting requirements imposed by the applicable insurance regulatory authority in its domiciliary State for the preceding 180 days; or,

in the case of a closed-end investment management

company registered under Section 8 of the Investment Company Act of 1940, such company has been subject to the applicable reporting requirements of Section 30 of the Investment Company Act of 1940 for the preceding 180 days.

B. The National Association of Securities Dealers (NASD) shall require that the issuer have a class of securities currently registered under Section 12 of the Securities Exchange Act of 1934; or in the case of an American Depositary Receipt issued against the equity securities of a foreign issuer, such equity securities are registered pursuant to Section 12 of the Securities Exchange Act of 1934; or the issuer is an insurance company meeting the conditions of Section 12(g)(2)(G) of the Securities Exchange Act of 1934 or is a closed-end investment management company registered under Section 8 of the Investment Company Act of 1940 with securities registered under the Securities Act of 1933.

C. The NASD shall require at least the following standards to be met for designation of securities of an issuer on the quotation system:

	Alt. No. 1	Alt. No. 2
Net Tangible Assets ¹	\$4,000,000	\$12,000,000
Public Float	500,000	1,000,000
Pre-Tax Income	750,000
Net Income	400,000
Shareholders ²	800/400	800/400
Market Value of Float	3,000,000	15,000,000
Minimum Bid	\$5/Share
Operating History	3 Years

¹ "Net Tangible Assets" is defined for purposes of this Rule to include the value of patents, copyrights, and trademarks but to exclude the value of good will.

² The minimum number of shareholders under each alternative is 800 for issuers with 500,000 to 1,000,000 shares publicly held or a minimum of 400 if the issuer has either (i) over 1 million shares publicly held or (ii) over 500,000 shares publicly held and average daily trading volume in excess of 2,000 shares per day for the six months preceding the transaction.

The rules of the NASD shall require at least two authorized market makers for each issuer.

D. The NASD shall require at least the following minimum corporate governance standards for its domestic issuers:

1. Distribution of Annual and Interim Reports.

a. Each issuer shall distribute to shareholders copies of an annual report containing audited financial statements of the company and its subsidiaries. The report shall be distributed to shareholders a

reasonable period of time prior to the company's annual meeting of shareholders and shall be filed with the NASD at the time it is distributed to shareholders.

b. Each issuer which is subject to SEC Rule 13a-13 shall make available to shareholders copies of quarterly reports including statements of operating results either prior to or as soon as practicable following the company's filing its Form 10-Q with the SEC. If the form of such quarterly report differs from the Form 10-Q, both the quarterly report and the Form 10-Q shall be filed with the NASD. The statement of operations contained in quarterly reports shall disclose, as a minimum, any substantial items of an unusual or nonrecurring nature, net income, and the amount of estimated federal taxes.

c. Each issuer which is not subject to SEC Rule 13a-13 and which is required to file with the SEC or another federal or state regulatory authority interim reports relating primarily to operations and financial position shall make available to shareholders reports which reflect the information contained in those interim reports. Such reports shall be made available to shareholders either before or as soon as practicable following filing with the appropriate regulatory authority. If the form of the interim report made available to shareholders differs from that filed with the regulatory authority, both the report to shareholders and the report to the regulatory authority shall be filed with the NASD.

2. Independent Directors. Each issuer shall maintain a minimum of two independent directors on its board of directors. For purposes of this section, "independent director" shall mean a person other than an officer or employee of the issuer or its subsidiaries or any other individual having a relationship which, in the opinion of the board of directors, would interfere with the exercise of independent judgment in carrying out the responsibilities of a director.

3. Audit Committee. Each issuer shall establish and maintain an audit committee, a majority of the members of which shall be independent directors.

4. Shareholder Meetings. Each issuer shall hold an annual meeting of shareholders and shall provide notice of such meeting to the NASD.

5. Quorum. Each issuer shall provide for a quorum as specified in its by-laws for any meeting of the holders of common stock; provided, however, that in no case shall such quorum be less than 33 1/3 percent of the outstanding shares of the issuer's common voting stock.

6. Solicitation of Proxies. Each issuer shall solicit proxies and provide proxy statements for all meetings of shareholders and shall provide copies of such proxy

solicitation to the NASD.

7. Conflicts of Interest. Each issuer shall conduct an appropriate review of all related party transactions on an ongoing basis and shall use the issuer's audit committee or a comparable body for the review of potential conflict of interest situations where appropriate.

8. Shareholder Approval Policy. Each issuer shall require shareholder approval of a plan or arrangement under a. below or, prior to the issuance of designated securities under b., c., or d. below, when:

a. A stock option or purchase plan is to be established or other arrangement made pursuant to which stock may be acquired by officers or directors, except for warrants or rights issued generally to security holders of the issuer or broadly based plans or arrangements including other employees (e.g. ESOP's). In a case where the shares are issued to a person not previously employed by the issuer, as an inducement essential to the individual's entering into an employment contract with the issuer, shareholder approval will generally not be required.

The establishment of a plan or arrangement under which the amount of securities which may be issued does not exceed the lesser of 1% of the number of shares of common stock, 1% of the voting power outstanding, or 25,000 shares will not generally require shareholder approval.

b. The issuance will result in a change of control of the issuer.

c. In connection with the acquisition of the stock or assets of another company if:

(1.) any director, officer or substantial shareholder of the issuer has a 5% or greater interest (or such persons collectively have a 10% or greater interest), directly or indirectly, in the company or assets to be acquired or in the consideration to be paid in the transaction or series of related transactions and the present or potential issuance of common stock, or securities convertible into or exercisable for common stock, could result in an increase in outstanding common shares or voting power of 5% or more; or

(2.) in the case of the present or potential issuance of common stock, or securities convertible into or exercisable for common stock, other than in a public offering for cash, where the common stock has or will have upon issuance voting power equal to or in excess of 20% of the voting power outstanding before the issuance of stock or securities convertible into or exercisable for common stock, or

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the number of shares of common stock to be issued is or will be equal to or in excess of 20% of the number of shares of common stock outstanding before the issuance of the stock or securities.

d. In connection with a transaction other than a public offering involving:

(1.) the sale or issuance by the issuer of common stock (or securities convertible into or exercisable for common stock) at a price less than the greater of book or market value which together with sales by officers, directors or substantial shareholders of the issuer equals 20% or more of common stock or 20% or more of the voting power outstanding before the issuance; or

(2.) the sale or issuance by the company of common stock (or securities convertible into or exercisable for common stock) equal to 20% or more of the common stock or 20% or more of the voting power outstanding before the issuance for less than the greater of book or market value of this stock.

e. Exceptions may be made upon application to the NASD when:

(1.) the delay in securing shareholder approval would seriously jeopardize the financial viability of the issuer and

(2.) reliance by the issuer on this exception is expressly approved by the issuer's audit committee or a comparable body.

A company relying on this exception must mail to all shareholders not later than ten days before issuance of the securities a letter alerting them to its omission to seek the shareholder approval that would otherwise be required and indicating that the issuer's audit committee of the Board or a comparable body has expressly approved the exception.

f. Only shares actually issued and outstanding (excluding treasury shares or shares held by a subsidiary) are to be used in making any calculation provided for in this paragraph 8. Unissued shares reserved for issuance upon conversion of securities or upon exercise of options or warrants will not be regarded as outstanding.

g. Voting power outstanding as used in this paragraph 8 refers to the aggregate number of votes which may be cast by holders of those securities outstanding which entitle the holders thereof to vote generally on all matters submitted to the issuer's security holders for a vote.

h. An interest consisting of less than either 5% of

the number of shares of common stock or 5% of the voting power outstanding of an issuer or party shall not be considered a substantial interest or cause the holder of such an interest to be regarded as a substantial security holder.

E. Voting Rights.

1. The NASD rules shall provide as follows: No rule, stated policy, practice, or interpretation shall permit the authorization for designation on the NASDAQ/National Market System ("authorization"), or the continuance of authorization, of any common stock or other equity security of a domestic issuer, if, on or after July 1, 1989, the issuer of such security issues any class of security, or takes other corporate action, with the effect of nullifying, restricting, or disparately reducing the per share voting rights of holders of an outstanding class or classes of common stock of such issuer registered pursuant to Section 12 of the Securities Exchange Act of 1934.

2. For the purposes of paragraph 1. of this Section, the following shall be presumed to have the effect of nullifying, restricting, or disparately reducing the per share voting rights of an outstanding class or classes of common stock:

a. Corporate action to impose any restriction on the voting power of shares of the common stock of the issuer held by a beneficial or record holder based on the number of shares held by such beneficial or record holder;

b. Corporate action to impose any restriction on the voting power of shares of the common stock of the issuer held by a beneficial or record holder based on the length of time such shares have been held by such beneficial or record holder;

c. Any issuance of securities through an exchange offer by the issuer for shares of an outstanding class of the common stock of the issuer, in which the securities issued have voting rights greater than or less than the per share voting rights of any outstanding class of the common stock of the issuer;

d. Any issuance of securities pursuant to a stock dividend, or any other type of distribution of stock, in which the securities issued have voting rights greater than the per share voting rights of any outstanding class of the common stock of the issuer.

3. For the purpose of paragraph 1. of this Section, the following, standing alone, shall be presumed not to have the effect of nullifying, restricting, or disparately reducing the per share voting rights of holders of an outstanding class or classes of common stock:

a. The issuance of securities pursuant to an initial registered public offering;

b. The issuance of any class of securities, through a registered public offering, with voting rights not greater than the per share voting rights of any outstanding class of the common stock of the issuer;

e. The issuance of any class of securities to effect a bona fide merger or acquisition, with voting rights not greater than the per share voting rights of any outstanding class of the common stock of the issuer;

d. Corporate action taken pursuant to state law requiring a state's domestic corporation to condition the voting rights of a beneficial or record holder of a specified threshold percentage of the corporation's voting stock on the approval of the corporation's independent shareholders.

4. Definitions. The following terms shall have the following meanings for purposes of this Section, and the rules of the NASD shall include such definitions for the purposes of the prohibition in paragraph 1. of this Section:

a. The term "common stock" shall include any security of an issuer designated as common stock and any security of an issuer, however designated, which, by statute or by its terms, is a common stock (e.g., a security which entitles the holders thereof to vote generally on matters submitted to the issuer's security holders for a vote).

b. The term "equity security" shall include any equity security defined as such pursuant to Rule 3a11-1 under the Securities Exchange Act of 1934.

e. The term "domestic issuer" shall mean an issuer that is not a "foreign private issuer" as defined in Rule 3b-4 under the Securities Exchange Act of 1934.

d. The term "security" shall include any security defined as such pursuant to Section 3(a)(10) of the Securities Exchange Act of 1934, but shall exclude any class of security having a preference or priority over the issuer's common stock as to dividends, interest payments, redemption or payments in liquidation, if the voting rights of such securities only become effective as a result of specified events, not relating to an acquisition of the common stock of the issuer, which reasonably can be expected to jeopardize the issuer's financial ability to meet its payment obligations to the holders of that class of securities.

F. Maintenance Criteria. After authorization for designation of a security on the NASDAQ/National Market System, the security must meet the following criteria in order for such designation to continue in effect:

1. The issuer of the security has net tangible assets of

at least:

a. \$2,000,000 if the issuer has sustained losses from continuing operations and/or net losses in two of its three most recent fiscal years; or

b. \$4,000,000 if the issuer has sustained losses from continuing operations and/or net losses in three of its four most recent fiscal years;

2. There are at least 200,000 publicly held shares;

3. There are at least 400 shareholders or at least 300 shareholders of round lots;

4. The aggregate market value of publicly held shares is at least \$1,000,000.

G. The Commission may rescind this order pursuant to its authority under Section 13.1-523 of the Act, thereby revoking this rule, if the Commission determines that the requirements of the NASDAQ/National Market System have been so changed or insufficiently applied so that the protection of investors is no longer afforded.

H. The Commission shall have the authority to deny or revoke the exemption created by this Rule as to a specific issue or category of securities.

I. The NASD shall promptly notify the Commission when an issue of securities is removed from NASDAQ/National Market System designation.

Rule 507 Solicitations of Interest Prior to the Filing of a Registration Statement

In accordance with Section 13.1-514.1 C of the Act, an offer, but not a sale, of a security made by or on behalf of an issuer for the sole purpose of soliciting an indication of interest in receiving a prospectus (or its equivalent) for such security is exempt from the securities registration requirements of the Act if all of the conditions set forth in Sections A through K, below, are satisfied:

A. The issuer is or will be a business entity organized under the laws of one of the states or possessions of the United States or one of the provinces or territories of Canada and is engaged in or proposes to engage in a business other than petroleum exploration or production or mining or other extractive industries.

B. The solicitation of interest is not for a so-called "blind pool" offering or other offering for which the specific business in which to be engaged or property to be acquired cannot be described at the time of the solicitation.

C. It is intended that the security be registered under the Act and that the offering be conducted pursuant to either Regulation A or Rule 504 of Regulation D, as

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promulgated by the U.S. Securities and Exchange Commission.

D. At least ten (10) business days prior to the initial solicitation of interest under this Rule, the offeror files with the Commission a Solicitation of Interest Form along with any other materials to be used to conduct solicitations of interest, including, but not limited to, the script of any broadcast to be made and a copy of any notice to be published.

E. At least five (5) business days prior to usage, the offeror files with the Commission any amendments to the materials specified in Section D, above, or additional materials to be used to conduct solicitations of interest, except for materials provided to a particular offeree pursuant to a request by that offeree, which materials shall be filed with the Commission no later than five (5) business days after usage.

F. No Solicitation of Interest Form, script, advertisement or other material which the offeror has been notified by the Commission not to distribute is used to solicit indications of interest.

G. Except for scripted broadcasts and except to the extent necessary to obtain information needed to provide a Solicitation of Interest Form, the offeror does not communicate with any offeree about the contemplated offering unless the offeree is provided with the most current Solicitation of Interest Form at or before the time of the communication or within five (5) calendar days from the communication.

H. During the solicitation of interest period, the offeror does not solicit or accept money or a commitment to purchase securities.

I. No sale is made until at least seven (7) calendar days after delivery to the purchaser of a prospectus which is part of a registration statement declared effective under Section 13.1-508 or Section 13.1-510 of the Act.

J. No offer or sale of the security is consummated by any person who is not registered under or exempted from registration by the Act as a broker-dealer or an agent.

K. The offeror does not know, and in the exercise of reasonable care, could not know that any of the issuer's officers, directors, ten percent shareholders or promoters:

1. Has filed a registration statement which is the subject of a currently effective registration stop order entered pursuant to any federal or state securities law within five years prior to the filing of the Solicitation of Interest Form.

2. Has been convicted within five years prior to the filing of the Solicitation of Interest Form of any felony or misdemeanor in connection with the offer, purchase or sale of any security or any felony

involving fraud or deceit, including but not limited to forgery, embezzlement, obtaining money under false pretenses, larceny, or conspiracy to defraud.

3. Is currently subject to any federal or state administrative enforcement order or judgment entered by any state securities administrator or the U.S. Securities and Exchange Commission within five years prior to the filing of the Solicitation of Interest Form or is subject to any federal or state administrative enforcement order or judgment entered within five years prior to the filing of the Solicitation of Interest Form in which fraud or deceit, including, but not limited to, making untrue statements of material facts and omitting to state material facts, was found.

4. Is subject to any federal or state administrative enforcement order or judgment which prohibits, denies, or revokes the use of any exemption from registration in connection with the offer, purchase or sale of securities.

5. Is currently subject to any order, judgment, or decree of any court of competent jurisdiction temporarily or preliminarily restraining or enjoining, or is subject to any order, judgment or decree of any court of competent jurisdiction, permanently restraining or enjoining, such party from engaging in or continuing any conduct or practice in connection with the purchase or sale of any security or involving the making of any false filing with the state entered within five years prior to the filing of the Solicitation of Interest Form. The prohibitions listed above shall not apply if the person subject to the disqualification is duly licensed or registered to conduct securities related business in the state in which the administrative order or judgment was entered against such person or if the broker-dealer employing such party is licensed or registered in this state and the Form B-D filed with this state discloses the order, conviction, judgment or decree relating to such person. No person disqualified under this Section K may act in a capacity other than that for which the person is licensed or registered. Any disqualification caused by this Section K is automatically waived if the agency which created the basis for disqualification determines upon a showing of good cause that it is not necessary under the circumstances that the exemption be denied.

L. A failure to comply with a term, condition or requirement of Sections A-K of this Rule will not result in the loss of the exemption from the securities registration requirements of the Act for any offer to a particular individual or entity if the offeror shows:

1. The failure to comply did not pertain to a term, condition or requirement directly intended to protect that particular individual or entity; and

2. The failure to comply was insignificant with

respect to the offering as a whole; and

3. A good faith and reasonable attempt was made to comply with all applicable terms, conditions and requirements of Sections A-K.

Where an exemption is established only through reliance upon this Section L, the failure to comply shall nonetheless be actionable by the Commission as a violation of the Act, and shall constitute grounds for denying or revoking the exemption as to a specific security or transaction.

M. The offeror shall comply with the requirements set forth below. Failure to comply will not result in the loss of the exemption from the securities registration requirements of the Act, but shall be a violation of the Act, be actionable by the Commission, and constitute grounds for denying or revoking the exemption as to a specific security or transaction.

1. Any published notice or script for broadcast and any printed material delivered apart from the Solicitation of Interest Form must contain at least the identity of the chief executive officer of the issuer, a brief and general description of its business and products, and the following legends:

a. NO MONEY OR OTHER CONSIDERATION IS BEING SOLICITED AND NONE WILL BE ACCEPTED;

b. NO SALES OF THE SECURITIES WILL BE MADE OR COMMITMENT TO PURCHASE ACCEPTED UNTIL DELIVERY OF AN OFFERING CIRCULAR THAT INCLUDES COMPLETE INFORMATION ABOUT THE ISSUER AND THE OFFERING;

c. AN INDICATION OF INTEREST MADE BY A PROSPECTIVE INVESTOR INVOLVES NO OBLIGATION OR COMMITMENT OF ANY KIND;

d. THIS OFFER IS BEING MADE PURSUANT TO AN EXEMPTION FROM REGISTRATION UNDER THE FEDERAL AND STATE SECURITIES LAWS. NO SALE MAY BE MADE UNTIL THE OFFERING STATEMENT IS QUALIFIED BY THE SEC AND THE SECURITIES ARE REGISTERED IN THIS STATE; and

e. REGISTRATION OF THE SECURITIES FOR SALE IN THIS STATE IS DEPENDENT ON COMPLIANCE WITH THE SECURITIES LAWS OF VIRGINIA. THEREFORE, THERE CAN BE NO ASSURANCE THAT THE SECURITIES WILL BE REGISTERED FOR SALE IN VIRGINIA.

This requirement shall not apply to the delivery of printed material to a person who has already received a Solicitation of Interest Form with the legends

correctly included.

2. All communications with offerees made in reliance on this Rule must cease after a registration statement is filed in this state, and no sale may be made until at least twenty (20) calendar days after the last communication made in reliance on this Rule.

N. Other than the requirements of Section J, above, the Commission may waive any condition of this exemption in writing, upon application by the offeror and good cause having been shown. Neither compliance nor attempted compliance with this Rule, nor the absence of any objection or order by the Commission with respect to any offer of securities undertaken pursuant to this Rule, shall be deemed to be a waiver of any condition of the Rule or deemed to be a confirmation by the Commission of the availability of this Rule.

O. Offers made in reliance on this Rule will not result in a violation of Section 13.1-507 of the Act by virtue of being integrated with subsequent offers or sales of securities unless such subsequent offers and sales would be integrated under federal securities laws.

P. Issuers on whose behalf indications of interest are solicited under this Rule may not make offers or sales in reliance on subsection B 7 or B 13 of Section 13.1-514 of the Act until six (6) months after the last communication with an offeree made pursuant to this Rule.

COMMENTS:

1. All communications made in reliance on this Rule are subject to the anti-fraud provisions of the Act.

2. Nothing in this Rule is intended to exempt any person from the broker-dealer or agent registration requirements of the Act.

3. The Commission may or may not review the materials filed pursuant to this Rule. Materials filed, if reviewed, will be judged under anti-fraud principles. Any discussion in the offering documents of the potential rewards of the investment must be balanced by a discussion of possible risks.

4. Any offer effected in violation of this Rule may constitute an unlawful offer of an unregistered security for which civil liability attaches under Section 13.1-522 of the Act. Likewise, any misrepresentation or omission may give rise to civil liability.

5. Issuers should note that under certain conditions the Commission may refuse to grant effectiveness to any registration statement filed under Section 13.1-508 or Section 13.1-510 of the Act. In that event, sales to prospective Virginia investors solicited under this Rule may not be consummated. Please refer to Section 13.1-513 of the Act, Rule 900, and Rule 402.

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NOTE TO USERS: The following form sets forth the minimum informational requirement for soliciting indications of interest under federal and state securities laws. You may include additional information if you think it necessary or desirable. Remember that any discussion in this document is subject to the anti-fraud provisions of the federal and state securities laws and must thereby be complete. Also, any discussion of potential rewards of the proposed investment must be balanced by a discussion of possible risks. You may alter the graphic presentation of the form in any way as long as the minimum information is clearly presented.

SOLICITATION OF INTEREST FORM

.....
NAME OF COMPANY

Street Address of Principal Office:

Company Telephone Number:

Date of Organization:

Amount of the Proposed Offering:

Name of the Chief Executive Officer:

THIS IS A SOLICITATION OF INTEREST ONLY. NO MONEY OR OTHER CONSIDERATION IS BEING SOLICITED AND NONE WILL BE ACCEPTED.

NO SALES OF THE SECURITIES WILL BE MADE OR COMMITMENT TO PURCHASE ACCEPTED UNTIL THE DELIVERY OF A FINAL OFFERING CIRCULAR THAT INCLUDES COMPLETE INFORMATION ABOUT THE COMPANY AND THE OFFERING.

AN INDICATION OF INTEREST MADE BY A PROSPECTIVE INVESTOR INVOLVES NO OBLIGATION OR COMMITMENT OF ANY KIND.

THIS OFFER IS BEING MADE PURSUANT TO AN EXEMPTION FROM REGISTRATION UNDER THE FEDERAL AND STATE SECURITIES LAWS. NO SALE MAY BE MADE UNTIL THE OFFERING STATEMENT IS QUALIFIED BY THE SEC AND THE SECURITIES ARE REGISTERED IN THIS STATE.

REGISTRATION OF THE SECURITIES FOR SALE IN THIS STATE IS DEPENDENT ON COMPLIANCE WITH THE SECURITIES LAWS OF VIRGINIA. THEREFORE, THERE CAN BE NO ASSURANCE THAT THE SECURITIES WILL BE REGISTERED FOR SALE IN VIRGINIA.

This Company

() Has never conducted business operations.

() Is in the development stage.

() Is currently conducting operations.

() Has shown a profit for the last fiscal year.

() Other (Specify)

BUSINESS:

1. Describe in general what business the company does or proposes to do, including what products or goods are or will be produced or services that are or will be rendered.

2. Describe in general how these products or services are to be produced or rendered and how and when the company intends to carry out its activities.

OFFERING PROCEEDS:

3. Describe in general how the company intends to use the proceeds of the proposed offering.

KEY PERSONNEL OF THE COMPANY:

4. Provide the following information for all officers and directors or persons occupying similar positions.

Name, Title, Office Street Address, Telephone Number, Employment History (Employers, titles and dates of positions held during the past five years), and Education (degrees, schools and dates).

(end of form)

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94-5

INTEREST RATES SECOND QUARTER 1994

Rates remain unchanged: State and certain local interest rates are subject to change every quarter based on changes in the federal rates established pursuant to I.R.C. § 6621. The federal rates for the second quarter of 1994 remain at 7% for tax underpayments (assessments), 6% for tax overpayments (refunds), and 9% for "large corporate underpayments" as defined in I.R.C. § 6621(c). Va. Code § 58.1-15 provides that the underpayment rate for Virginia taxes will be 2% higher than the corresponding federal rates. Accordingly, the Virginia rates for the second quarter of 1994 remain at 9% for tax underpayments, 6% for tax overpayments, and 11% for "large corporate underpayments".

Rate for Addition to Tax for Underpayments of Estimated Tax

Taxpayers whose taxable year ends on March 31, 1994: For the purpose of computing the addition to the tax for underpayment of Virginia estimated income taxes on Form 760C (for individuals, estates and trusts), Form 760F (for farmers and fishermen) or Form 500C (for corporations), the first quarter 9% underpayment rate will apply through the due date of the return, July 15, 1994.

Individuals: Tax returns for the calendar year 1993 are due on May 2, 1994. For the purpose of computing the addition to the tax for underpayment of Virginia estimated income taxes on Form 760C (for individuals, estates and trusts) or Form 760F (for farmers and fishermen), the first quarter 9% underpayment rate will apply through the due date of the return, May 2, 1994.

Local Tax

Assessments: Localities assessing interest on delinquent taxes pursuant to Va. Code § 58.1-3916 may impose interest at a rate not to exceed 10% for the first year of delinquency, and at a rate not to exceed 10% or the federal underpayment rate in effect for the applicable quarter, whichever is greater, for the second and subsequent years of delinquency. For the second quarter of 1994, the federal underpayment rate is 7%.

Refunds: Localities which have provided for refund of erroneously assessed taxes may provide by ordinance that such refund be repaid with interest at a rate which does not exceed the rate imposed by the locality for delinquent taxes.

Recent Interest Rates

Accrual Period		Overpayment	Underpayment	Large Corporate
<u>Beginning</u>	<u>Through</u>	<u>(Refund)</u>	<u>(Assessment)</u>	<u>Underpayment</u>
1-Jan-87	30-Sep-87	8%	9%	—
1-Oct-87	31-Dec-87	9%	10%	—
1-Jan-88	31-Mar-88	10%	11%	—
1-Apr-88	30-Sep-88	9%	10%	—
1-Oct-88	31-Mar-89	10%	11%	—
1-Apr-89	30-Sep-89	11%	12%	—
1-Oct-89	31-Mar-91	10%	11%	—
1-Apr-91	30-Jun-91	9%	10%	—
1-Jul-91	31-Dec-91	9%	12%	14%
1-Jan-92	31-Mar-92	8%	11%	13%
1-Apr-92	30-Sep-92	7%	10%	12%
1-Oct-92	30-Jun-94	6%	9%	11%

For additional information: Contact the Taxpayer Assistance Section, Office of Taxpayer Services, Virginia Department of Taxation, P. O. Box 1880, Richmond, Virginia 23282-1880, or call the following numbers for additional information about interest rates and penalties.

Individual & Fiduciary Income Tax	(804) 367-8031
Corporation Income Tax	(804) 367-8036
Withholding Tax	(804) 367-8037
Soft Drink Excise Tax	(804) 367-8098
Aircraft Sales & Use Tax	(804) 367-8098
Other Sales & Use Taxes	(804) 367-8037

GOVERNOR

EXECUTIVE MEMORANDUM 5-94

Subject: Establishment of Schedule and Format for Agency Assessment of Mandates on Local Government

Purpose: The purpose of this Memorandum is to establish a process, pursuant to the provisions of §§ 2.1-7.1 and 15.1-945.3(6) of the Code of Virginia, by which the executive agencies of this Commonwealth shall critically assess and periodically reassess all the state and/or federal mandates which they administer, for the purpose of determining which mandates, if any, may be altered or eliminated without interruption of local service delivery and without undue threat to the health, safety, and welfare of the residents of Virginia.

Requirements:

1. Assessment of Current Mandates

The executive agencies of the Commonwealth shall assess all local government mandates which they currently administer, as determined by the Commission on Local Government based upon the Joint Legislative Audit and Review Commission's publication, 1993 Update: Catalog of State and Federal Mandates on Local Governments (House Document No. 2/1994), as follows:

(a) Those agencies administering ten (10) or fewer mandates shall complete the assessment of all such mandates by March 31, 1995.

(b) Those agencies administering more than ten (10) such mandates shall complete the assessment of no less than one-half of such mandates, but not less than ten (10), by March 31, 1995, and shall complete the assessment of the remainder of such mandates by June 30, 1996. As of October 1, 1993, the following agencies administered more than ten (10) mandates:

Department of Criminal Justice Services
Department of Education
Department of Environmental Quality
Department of Housing and Community Development
Department of Social Services
Department of Transportation

Provided, however, that in all cases the agency administering the mandate shall provide its assessment and recommendation to the appropriate Cabinet Secretary in sufficient time for the Secretary to endorse or amend the agency's finding. The Cabinet Secretary may extend the review period specified in this document if such an extension would serve to enhance the review.

2. Priorities

Agencies shall give priority to the assessment of those

mandates classified by House Document No. 2/1994 as "Compulsory Orders," with those mandates termed "Conditions of State and Federal Financial Aid" and "State and Federal Regulation of Optional Activities" being given lower priority.

3. Annual Specification of Schedule

(a) Agencies shall submit to the Commission on Local Government by December 15, 1994, a proposed schedule establishing specific dates for the commencement and completion of those assessments required by March 31, 1995, and a listing of other assessments, if any, due for completion thereafter.

(b) Agencies shall submit to the Commission on Local Government by October 15, 1994, a proposed schedule establishing specific dates for the commencement and completion of all other assessments required by June 30, 1996.

(c) Agencies shall submit to the Commission on Local Government by October 15 of each subsequent year a proposed schedule establishing specific dates for the assessment of new mandates, as specified in Section 9 of this Memorandum, or for the reassessment of existing mandates, as may be appropriate pursuant to § 15.1-945.3(6), Code of Virginia, and as specified in Section 10 of this Memorandum.

(d) All schedules and listings submitted to the Commission pursuant to this Section shall, at a minimum, identify each mandate listed therein by its placement and description in House Document 2/1994 or in the latest catalog of state and federal mandates published by the Commission on Local Government pursuant to Sec. 15.1-945.3(7) of the Code of Virginia.

4. Commission Adoption of Schedule

The Commission on Local Government shall, in January 1994 and in November of each year thereafter, adopt the proposed assessment schedules submitted annually by the agencies unless, in its judgment, and with the concurrence of the Secretary and the Governor, substantial reason exists for modification.

5. Secretarial and Gubernatorial Approval

(a) The Commission on Local Government shall submit to the Secretary of Administration and the Governor for review and approval the schedules which it has adopted as follows:

(i) by February 1, 1994, for those assessments due to be completed by March 31, 1995;

(ii) by December 1, 1994, for those assessments due

to be completed by June 30, 1996;

(iii) by December 1 of each year thereafter for those assessments due to be completed in subsequent periods.

(b) Subject to approval of the assessment schedules by the Secretary of Administration and the Governor, the Commission shall forward copies of the adopted schedules to the affected agencies.

6. Schedule Modifications

Approved agency assessment schedules may subsequently be modified by the Commission with due notice and sufficient cause upon request of the administering agency, affected local governments, the Virginia Municipal League (VML), the Virginia Association of Counties (VACo), or upon its own initiative. All modifications in agency assessment schedules approved by the Commission shall be subject to the concurrence of the Secretary of Administration and the Governor.

7. Filing of Assessment Schedules

The Commission on Local Government shall file with the Clerks of the House of Delegates and the Senate copies of all mandate assessment schedules and any modifications thereof following their approval by the Secretary of Administration and the Governor. The Commission shall also file copies of such approved schedules and modifications with the VML, with VACo, and with the Registrar of Regulations for appropriate publication in The Virginia Register.

8. New Mandates

The Commission on Local Government shall identify, in conjunction with its annual preparation of a catalog of state and federal mandates, as prescribed by § 15.1-945.3(7) of the Code of Virginia, all new local government mandates not specified in House Document No. 2/1994. The executive agencies administering such new mandates shall be responsible for their assessment consistent with the other relevant sections of this Memorandum. However, notwithstanding any other provision of this Memorandum, no mandate shall be subject to assessment by any agency until it has been in effect for a minimum of 24 months.

9. Reassessment of Mandates

Pursuant to § 15.1-945.3(6) of the Code of Virginia, the Commission on Local Government shall, after consultation with the affected agencies, periodically call for scheduling the reassessment of mandates. Provided, however, that no mandate shall be subject to assessment more than once in any four-year period unless it has been subject to modifications so

substantial that the modifications have, in essence, created a new mandate. All reassessments shall be scheduled and conducted consistent with the other relevant sections of this Memorandum.

10. Assessment Process

All assessments performed by agencies pursuant to §§ 2.1-7.1 and 15.1-945.3(6) of the Code of Virginia shall be conducted consistent with the standardized assessment form prescribed by the Commission on Local Government and appended to this Memorandum.

11. Submission and Distribution of Assessments

Agencies shall submit to the Commission on Local Government all completed assessments, signed by the agency head, no later than the date specified for each mandate in the approved schedule. The Commission on Local Government shall distribute copies of all assessments completed by state agencies to the Governor, the Secretary of Administration, the Clerks of the Senate and House of Delegates, the VML, VACo, and to other interested parties upon request.

Effective Date: This Executive Memorandum shall become effective April 22, 1994, and shall remain in force and effect until superseded or rescinded by further Executive Memorandum or by Executive Order.

/s/ George Allen

Governor

FORMAT FOR ASSESSMENT OF STATE AND FEDERAL MANDATES ON VIRGINIA LOCAL GOVERNMENTS (PURSUANT TO SEC. 2.1-7.1, CODE OF VA.)

.....
(Administering Agency)

.....
(Date of Submission)

[Instructions: Please type your assessment on separate paper following the headings provided below.]

- A. Short Title of Mandate (5 words or less):
- B. Specific Provisions of Mandate (10 lines or less):
- C. Source/Authority:
 - 1. Specify Each Applicable (with citations):
 - a) Federal Statute:
 - b) Federal Regulation:
 - c) State Statute:
 - d) State Regulation:

e) Other:

2. Extension of Federal Mandates by State Authority:

(Where the mandate is founded concurrently on State and federal authority, describe specifically those additional elements or details prescribed by State authority.)

D. Method by Which Agency Oversees Implementation of Mandate:

E. Fiscal Impact of Mandate on Localities:

1. Localities Affected:

2. Funding of Mandate:

a) Funding Formula:

(Indicate separately both State and federal contributions to cost of mandate in dollar amount and as a percentage of total cost of implementation.)

b) Estimated Range of Costs to Localities:

(Give the range of costs of compliance for localities and indicate specific factors affecting local impact.)

c) Explanation of Estimation Methodology:

F. Effectiveness of Mandate in Accomplishing Purpose:

1. General Purpose of Mandate:

(Explain briefly the overall objective this mandate is intended to accomplish.)

2. Description of Essentiality to the Public Safety

(Describe the manner and the extent to which the mandate has protected and/or improved the health, safety, and welfare of residents of the Commonwealth. Describe the essential public purpose that this mandate accomplishes.)

G. Alternative Approaches to Achieving Purpose of Mandate:

1. Identification of Alternative Approaches:

2. Fiscal Impact of Alternative Approaches:

a) Estimated Change in Range of Costs to Localities of Alternative Approaches:

(Give the anticipated change in range of costs of compliance for localities and indicate specific factors affecting the variation in local impact.)

b) Estimated Change in Range of Costs to State of Alternative Approaches:

c) Explanation of Estimation Methodologies:

H. Agency Recommendation re Retention, Alteration, or Elimination of Mandate:

1. Determination by Agency:

2. Rationale:

I. Agency Contact re Assessment:

1. Name/Title:

2. Address/Telephone:

.....
(Signature of Agency Head)

V.A.R. Doc. No. R94-955; Filed May 3, 1994, 3:24 p.m.

GOVERNOR'S COMMENTS ON PROPOSED REGULATIONS

(Required by § 9-6.12:9.1 of the Code of Virginia)

BOARD OF CORRECTIONS

Title of Regulation: **VR 230-30-005:1. Standards for Planning, Design, Construction and Reimbursement of Local Correctional Facilities.**

Governor's Comment:

I reserve my right to make final comments on this regulation after review of the public's comments.

/s/ George Allen
Governor
Date: May 10, 1994

V.A.R. Doc. No. R94-961; Filed May 11, 1994, 9:19 a.m.

DEPARTMENT OF HEALTH (STATE BOARD OF)

Title of Regulation: **VR 355-30-109. Virginia Medical Facilities Plan: Diagnostic Imaging Services.**

Governor's Comment:

I reserve my right to make final comments on this regulation after review of the public's comments.

/s/ George Allen
Governor
Date: May 3, 1994

V.A.R. Doc. No. R94-956; Filed May 4, 1994, 2:03 p.m.

Governor

DEPARTMENT OF MINES, MINERALS AND ENERGY

Board of Examiners

Title of Regulation: VR 480-04-02. Board of Examiners
Certification Regulations.

Governor's Comment:

I reserve my right to make final comments on this
regulation after review of the public's comments.

/s/ George Allen

Governor

Date: May 10, 1994

VA.R. Doc. No. R94-992; Filed May 12, 1994, 7:51 a.m.

GENERAL NOTICES/ERRATA

Symbol Key †
† Indicates entries since last publication of the Virginia Register

GENERAL NOTICES

SECRETARY OF THE COMMONWEALTH

Notice to Counties, Cities, Towns, Authorities, Commissions, Districts and Political Subdivisions of the Commonwealth

Notice is hereby given that pursuant to § 2.1-71 of the Code of Virginia, each county, city and town and each authority, commission, district or other political subdivision of the Commonwealth to which any money is appropriated by the Commonwealth or any of the above which levies

any taxes or collects any fees or charges for the performance of public services or issues bonds, notes or other obligations, shall annually file with the Secretary of the Commonwealth a list of all bond obligations, the date and amount of the obligation and the outstanding balance therein, on or before June 30 of each year.

A copy of the form for use herein described follows.

Contact: Sheila A. Evans, Conflict of Interest and Appointments Specialist, P. O. Box 2454, Richmond, VA 23201-2454, Old Finance Building, Capitol Square, Richmond, VA 23219, telephone (804) 786-2441.

OFFICIAL TITLE OF POLITICAL SUBDIVISION: _____
ADDRESS: _____

FILING FORM PER §2.1-71 OF THE CODE OF VIRGINIA - 1994
OFFICE OF THE SECRETARY OF THE COMMONWEALTH

Type of
Obligation

Date Issued

Amount
of Issue

Balance Outstanding

Type of Project
Financed

General Notices/Errata

DEPARTMENT OF HEALTH

† Maternal and Child Health Block Grant Application Fiscal Year 1994

The Virginia Department of Health will transmit to the federal Secretary of Health and Human Services by July 15, 1994, the Maternal and Child Health Services Block Grant Application for the period October 1, 1994, through September 30, 1995, in order to be entitled to receive payments for the purpose of providing maternal and child health services on a statewide basis. These services include:

- ° preventive and primary care services for pregnant women, mothers and infants up to age 1
- ° preventive and primary care services for children and adolescents
- ° family-centered, community-based, coordinated care and the development of community-based systems of services for children with special health care needs

The Maternal and Child Health Services Block Grant Application makes assurance to the Secretary of Health and Human Services that the Virginia Department of Health will adhere to all the requirements of Section 505, Title V - Maternal and Child Health Services Block Grant of the Social Security Act, as amended. To facilitate public comment, this notice is to announce a period from May 25 through June 24, 1994, for review and public comment on the Block Grant Application. Copies of the document will be available as of May 25, 1994, in the office of the director of each county and city health department. Individual copies of the document may be obtained by contacting Ms. Mary M. Carpenter at the following address; written comments must be addressed to Ms. Carpenter and received by June 24, 1994, at the following address:

Virginia Department of Health
Division of Women's and Infants' Health
1500 East Main Street, Room 136
Richmond, Virginia 23219-2448
(804) 786-5916
FAX (804) 371-6032

DEPARTMENT OF LABOR AND INDUSTRY

Notice to the Public

The Virginia State Plan for the enforcement of Virginia Occupational Safety and Health (VOSH) laws commits the Commonwealth to adopt regulations identical to, or as effective as, those promulgated by the U.S. Department of Labor, Occupational Safety and Health Administration (OSHA). Accordingly, public participation in the formulation of such regulations must be made during the adoption of such regulations at the federal level. Therefore, the Virginia Department of Labor and Industry

is reissuing the following federal OSHA notice:

U. S. Department of Labor
Occupational Safety and Health Administration
29 CFR Parts 1910, 1915, 1926, and 1928
[Docket No. H-22]

INDOOR AIR QUALITY

AGENCY: Occupational Safety and Health Administration (OSHA)

ACTION: Notice of proposed rulemaking; notice of informal public hearing

SUMMARY: By this notice, the Occupational Safety and Health Administration (OSHA) proposes to adopt standards addressing indoor air quality in indoor work environments. The basis for this proposed action is a preliminary determination that employees working in indoor work environments face a significant risk of material impairment to their health due to poor indoor air quality, and that compliance with the provisions proposed in this notice will substantially reduce that risk.

The provisions of the standard are proposed to apply to all indoor "nonindustrial work environments." In addition, all worksites, both industrial and nonindustrial within federal OSHA's jurisdiction are covered with respect to the proposed provisions addressing control of environmental tobacco smoke. The proposal would require affected employers to develop a written indoor air quality compliance plan and implement that plan through actions such as inspection and maintenance of building systems which influence indoor air quality.

Provisions under the standard also propose to require employers to implement controls for specific contaminants and their sources such as outdoor air contaminants, microbial contamination, maintenance and cleaning chemicals, pesticides, and other hazardous chemicals within indoor work environments. Designated smoking areas which are to be separate, enclosed rooms exhausted directly to the outside are proposed to be required in buildings where the smoking of tobacco products is not prohibited. Specific provisions are also proposed to limit the degradation of indoor air quality during the performance of renovation, remodeling and similar activities. Provisions for information and training of building system maintenance and operation workers and other employees within the facility are also included in this notice.

Finally, proposed provisions in this notice address the establishment, retention, availability, and transfer of records such as inspection and maintenance records, records of written compliance programs, and employee complaints of building-related illness.

The agency invites the submission of written data, views and comments on all regulatory provisions proposed in this notice, and on all relevant issues pertinent to those

provisions. Federal OSHA is also scheduling an informal public hearing where persons may orally submit their views. It is noted here that subsequent Federal Register notices may be published subsequent to this notice if the public presents views leading to a substantial change in focus or it is otherwise determined to be appropriate.

DATES: Comments on the proposed standard must be postmarked by June 29, 1994. Notices of intention to appear must be postmarked by June 20, 1994. Testimony and evidence to be submitted at the hearing must be postmarked by July 5, 1994. The hearing will commence at 9:30 a.m. on July 12, 1994.

ADDRESS: Comments are to be submitted in quadruplicate or one original and one disk (5 1/4 or 3 1/2) in WP 5.0, 6.0 or Ascii to The Docket Office, Docket No. H-122, Room N-2625, U. S. Department of Labor, 200 Constitution Avenue, N. W., Washington, D. C. 20210, telephone (202) 219-7894. Any information not contained on disk, e.g., studies, articles, etc., must be submitted in quadruplicate.

An additional copy should be submitted to the Director of Enforcement Policy, Virginia Department of Labor and Industry, 13 S. 13th Street, Richmond, VA 23219.

Notices of intention to appear and testimony and evidence are to be submitted in quadruplicate to Tom Hall, Division of Consumer Affairs, Occupational Safety and Health Administration, U. S. Department of Labor, 200 Constitution Avenue, N. W., Room N-3649, Washington, D. C. 20210, telephone (202) 219-8615.

The hearing will be held in the auditorium of the U. S. Department of Labor, 200 Constitution Avenue, N. W., Washington, D. C.

FOR FURTHER INFORMATION CONTACT: Proposal: Mr. James F. Foster, Director of Information and Consumer Affairs, Occupational Safety and Health Administration, U. S. Department of Labor, Room N-3641, 200 Constitution Avenue, N.W., Washington, D. C. 20210, telephone (202) 219-8151.

Informal Hearing Information: Tom Hall, Division of Consumer Affairs, Occupational Safety and Health Administration, U. S. Department of Labor, Room N-3649, 200 Constitution Avenue, N.W., Washington, D. C. 20210, telephone (202) 219-8615.

* * * * *

† Notice to the Public

The State Plan for the enforcement of Virginia Occupational Safety and Health (VOSH) laws commits the Commonwealth to adopt regulations identical to, or as effective as, those promulgated by the U.S. Department of Labor, Occupational Safety and Health Administration (OSHA). Accordingly, public participation in the formulation of such regulations must be made during the

adoption of such regulations at the federal level. Therefore, the Virginia Department of Labor and Industry is reissuing the following federal OSHA notice:

U. S. Department of Labor
Occupational Safety and Health Administration
29 CFR Part 1903
[Docket No. C-03]
Abatement Verification

AGENCY: Occupational Safety and Health Administration (OSHA)

ACTION: Notice of proposed rulemaking

SUMMARY: The Occupational Safety and Health Administration (OSHA) is developing a regulation requiring employers to certify abatement and submit abatement plans and progress reports as a result of OSHA citations. In addition, federal OSHA is proposing the placement of a tag on cited equipment to alert affected employees that a hazardous condition exists while abatement is being accomplished. Violation of the regulation would result in civil penalties as prescribed by section 17 of the Occupational Safety and Health Act of 1970. This notice invites interested parties to submit comments and recommendations on the issues detailed in this document, as well as other pertinent issues. All of the information received in response to this notice will be carefully reviewed. The comments received will assist federal OSHA in developing final regulation.

DATES: Written comments on the notice of proposed rulemaking must be postmarked no later than July 18, 1994.

ADDRESS: Comments and information should be submitted in quadruplicate to the Docket Officer, Docket No. C-03, Occupational Safety and Health Administration, Room N-2625, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. Telephone: (202) 219-7894.

An additional copy should be submitted to the Director of Enforcement Policy, Virginia Department of Labor and Industry, 13 South Thirteenth Street, Richmond, VA 23219.

FOR FURTHER INFORMATION CONTACT: Mr. James F. Foster, Occupational Safety and Health Administration, Office of Public Affairs, Room N-3647, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. Telephone: (202) 219-8151.

SUPPLEMENTARY INFORMATION: The purpose of this proposed rule is to require employers to inform OSHA and their employees about measures they will take or have taken in response to OSHA citations, as well as to inform employees about OSHA citations and the alleged safety or health hazards described therein.

General Notices/Errata

VIRGINIA CODE COMMISSION

NOTICE TO STATE AGENCIES

Mailing Address: Our mailing address is: Virginia Code Commission, 910 Capitol Street, General Assembly Building, 2nd Floor, Richmond, VA 23219. You may FAX in your notice; however, we ask that you FAX two copies and do not follow up with a mailed copy. Our FAX number is: 371-0169.

FORMS FOR FILING MATERIAL ON DATES FOR PUBLICATION IN THE VIRGINIA REGISTER OF REGULATIONS

All agencies are required to use the appropriate forms when furnishing material and dates for publication in The Virginia Register of Regulations. The forms are supplied by the office of the Registrar of Regulations. If you do not have any forms or you need additional forms, please contact: Virginia Code Commission, 910 Capitol Street, General Assembly Building, 2nd Floor, Richmond, VA 23219, telephone (804) 786-3591.

FORMS:

NOTICE of INTENDED REGULATORY ACTION - RR01
NOTICE of COMMENT PERIOD - RR02
PROPOSED (Transmittal Sheet) - RR03
FINAL (Transmittal Sheet) - RR04
EMERGENCY (Transmittal Sheet) - RR05
NOTICE of MEETING - RR06
AGENCY RESPONSE TO LEGISLATIVE OR GUBERNATORIAL OBJECTIONS - RR08
DEPARTMENT of PLANNING AND BUDGET (Transmittal Sheet) - DPBRR09

ERRATA

DEPARTMENT OF TRANSPORTATION (COMMONWEALTH TRANSPORTATION BOARD)

Title of Regulation: VR 385-01-2. Fares for the Jamestown-Scotland Ferry.

Publication: 10:15 VA.R. 3990 April 18, 1994.

Correction to Final Regulation:

Page 3990, column 2, line 12, after "Pedestrians" insert ", Motorcycles"

Page 3990, column 2, line 13, after "Commuter Book Tickets," on the following line, insert "Commuter ticket books expire 180 days after date of purchase."

CALENDAR OF EVENTS

Symbols Key

- † Indicates entries since last publication of the Virginia Register
- ♿ Location accessible to handicapped
- ☎ Telecommunications Device for Deaf (TDD)/Voice Designation

NOTICE

Only those meetings which are filed with the Registrar of Regulations by the filing deadline noted at the beginning of this publication are listed. Since some meetings are called on short notice, please be aware that this listing of meetings may be incomplete. Also, all meetings are subject to cancellation and The Virginia Register deadline may preclude a notice of such cancellation.

For additional information on open meetings and public hearings held by the Standing Committees of the Legislature during the interim, please call Legislative Information at (804) 786-6530.

VIRGINIA CODE COMMISSION

EXECUTIVE

DEPARTMENT FOR THE AGING

July 2, 1994 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Department for the Aging intends to **repeal** regulations entitled: **VR 110-01-01. Public Participation Guidelines** and **adopt** regulations entitled: **VR 110-01-01:1. Public Participation Guidelines**. The proposed regulation establishes guidelines for the involvement of the public in the development and promulgation of department regulations.

Statutory Authority: §§ 2.1-373 and 9-6.14:7.1 of the Code of Virginia.

Contact: Bill Fascitelli, Senior Planner, Department for the Aging, 700 E. Franklin St., 10th Floor, Richmond, VA 23219-2327, telephone (804) 225-2852 or toll-free 1-800-552-4464.

DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES (STATE BOARD OF)

Virginia Egg Board

June 24, 1994 - 10 a.m. – Open Meeting

The Cavalier Hotel, Ocean Front at 42nd Street, Virginia Beach, Virginia. ☎

The board will meet to discuss business matters pertaining to the egg industry and the Virginia Egg Board. Any person who needs any accommodation in order to participate at the meeting should contact Cecilia Glembocki, Program Director, at least five days prior to the meeting so that suitable arrangements can be made. The board will entertain public comment at the conclusion of all other business for a period not to exceed 30 minutes.

Contact: Cecilia Glembocki, Program Director, Virginia Egg Board, 911 Saddleback Court, McLean, VA 22102, telephone (703) 790-1984.

Virginia Marine Products Board

June 14, 1994 - 5:30 p.m. – Open Meeting

Sewell's Ordinary Restaurant, Route 17, Gloucester, Virginia. ☎

The board will meet to receive reports from the Executive Director of the Virginia Marine Products Board on finance, marketing, past and future program planning, publicity/public relations, and old/new business. Any person who needs any accommodation in order to participate at the meeting should contact the agency before the meeting date, so that suitable arrangements can be made for any appropriate accommodation. The board will entertain public comment at the conclusion of all other business for a period not to exceed 30 minutes.

Contact: Shirley Estes, Executive Director, Virginia Marine Products Board, 554 Denbigh Boulevard, Suite B, Newport News, VA 23602, telephone (804) 874-3474.

Pesticide Control Board

June 28, 1994 - 10 a.m. – Open Meeting

Department of Agriculture and Consumer Services, Washington Building, 4th Floor Conference Room, 1100 Bank Street, Richmond, Virginia. ☎

The Policy and Procedures Committee will convene for the purpose of formulating a proposal to be presented to the full board at the July meeting on the regulation of commercial applicators not-for-hire. This is a continuation of the April 14-15, 1994, board meeting.

Portions of the meeting may be held in closed session pursuant to § 2.1-344 of the Code of Virginia. Any person who needs any accommodations in order to

Calendar of Events

participate at the meeting should contact Dr. Marvin A. Lawson at least 10 days before the meeting so that suitable arrangements can be made for any appropriate accommodations.

Contact: Dr. Marvin A. Lawson, Program Manager, Office of Pesticide Management, Department of Agriculture and Consumer Services, P. O. Box 1163, 1100 Bank Street, Room 401, Richmond, VA 23209, telephone (804) 371-6558.

Virginia Winegrowers Advisory Board

† **July 5, 1994 - 10 a.m. - Open Meeting**
The State Capitol, Capitol Square, House Room 1, Richmond, Virginia. ☒

A meeting to hear committee and project monitor reports and review old and new business. Public comment is welcome following the conclusion of board business.

Any person who needs any accommodation in order to participate at the meeting should contact Wendy Rizzo, identified in this notice, at least 14 days before the meeting date so that suitable arrangements can be made for any appropriate accommodation.

Contact: Wendy Rizzo, Secretary, Virginia Winegrowers Advisory Board, 1100 Bank Street, Suite 1009, Richmond, VA 23219, telephone (804) 786-0481.

VIRGINIA BOARD FOR ASBESTOS LICENSING

† **June 13, 1994 - 9 a.m. - Open Meeting**
Department of Professional and Occupational Regulation, 3600 West Broad Street, Conference Room 3, Richmond, Virginia. ☒

A general meeting.

Contact: David E. Dick, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8595 or (804) 367-9753/TDD ☒

AUCTIONEERS BOARD

June 7, 1994 - 9 a.m. - Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, Richmond, Virginia. ☒

A meeting to conduct regular board business and other matters which may require board action.

Contact: Geralde W. Morgan, Board Administrator, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230-4917, telephone (804) 367-8534.

BOARD FOR BARBERS

June 6, 1994 - 9 a.m. - Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, 4th Floor, Richmond, Virginia. ☒

A meeting to:

1. Review applications
2. Review correspondence
3. Conduct review and disposition of enforcement files
4. Conduct regulatory review
5. Conduct routine board business.

A public comment period will be scheduled during the meeting. No public comment will be accepted after that period. However, the meeting is open to the public. Any person who needs any accommodations in order to participate at the meeting should contact Les Newton at (804) 367-8590 at least 10 days before the meeting date so that suitable arrangements can be made.

Contact: Nancy T. Feldman, Assistant Director, Board for Barbers, 3600 W. Broad St., Richmond, VA 23230-4917, telephone (804) 367-8590.

CHESAPEAKE BAY LOCAL ASSISTANCE BOARD

† **June 2, 1994 - 10 a.m. - Open Meeting**
Location to be determined. ☒ (Interpreter for the deaf provided upon request)

The board will conduct general business, including review of local Chesapeake Bay Preservation Area programs. Public comment will be taken early in the meeting. A tentative agenda is available from the Chesapeake Bay Local Assistance Department.

Contact: Receptionist, Chesapeake Bay Local Assistance Department, 805 E. Broad St., Richmond, VA 23219, telephone (804) 225-3440, toll free 1-800-243-7229/TDD.

Central Area Review Committee

June 16, 1994 - 2 p.m. - Open Meeting
Chesapeake Bay Local Assistance Department, 8th Street Office Building, 8th and Broad Streets, 7th Floor Conference Room, Richmond, Virginia. ☒ (Interpreter for the deaf provided upon request)

The committee will review Chesapeake Bay Preservation Area programs for the Central Area. Persons interested in observing should call the Chesapeake Bay Local Assistance Department to verify meeting time, location and schedule. Public comment will not be received at the committee meeting. However, written comments are welcome.

Contact: Receptionist, Chesapeake Bay Local Assistance

Calendar of Events

Department, 805 E. Broad Street, Richmond, VA 23219, telephone (804) 225-3440 or toll free 1-800-243-7229/TDD ☎

Northern Area Review Committee

June 9, 1994 - 10 a.m. - Open Meeting

Chesapeake Bay Local Assistance Department, 8th Street Office Building, 8th and Broad Streets, 7th Floor, Conference Room, Richmond, Virginia. ☒ (Interpreter for the deaf provided upon request)

The committee will review Chesapeake Bay Preservation Area programs for the Northern Area. Persons interested in observing should call the Chesapeake Bay Local Assistance Department to verify meeting time, location and schedule. Public comment will not be received at the committee meeting. However, written comments are welcome.

Contact: Receptionist, Chesapeake Bay Local Assistance Department, 805 E. Broad Street, Richmond, VA 23219, telephone (804) 225-3440 or toll free 1-800-243-7229/TDD ☎

Southern Area Review Committee

June 22, 1994 - 10 a.m. - Open Meeting

Chesapeake Bay Local Assistance Department, 8th Street Office Building, 8th and Broad Streets, 7th Floor, Conference Room, Richmond, Virginia. ☒ (Interpreter for the deaf provided upon request)

The committee will review Chesapeake Bay Preservation Area programs for the Southern Area. Persons interested in observing should call the Chesapeake Bay Local Assistance Department to verify meeting time, location and schedule. Public comment will not be received at the committee meeting. However, written comments are welcome.

Contact: Receptionist, Chesapeake Bay Local Assistance Department, 805 E. Broad Street, Richmond, VA 23219, telephone (804) 225-3440 or toll free 1-800-243-7229/TDD ☎

CHILD DAY-CARE COUNCIL

† June 9, 1994 - 9:30 a.m. - Open Meeting

Theater Row Building, 730 East Broad Street, Lower Level Conference Rooms 1 and 2, Richmond, Virginia. ☒ (Interpreter for the deaf provided upon request)

A meeting to discuss issues, concerns and programs that impact child day centers, camps, school age programs, and preschool/nursery schools. The public comment period will be 10 a.m. Please call ahead of time for possible changes in meeting time.

Contact: Peggy Friedenber, Legislative Analyst, Office of Governmental Affairs, Department of Social Services, Theater Row Building, 730 E. Broad St., Richmond, VA 23219, telephone (804) 692-1820.

BOARD ON CONSERVATION AND DEVELOPMENT OF PUBLIC BEACHES

June 8, 1994 - 10:30 a.m. - Open Meeting

York County Human Services Building, Recreational Services Office Community Room, 301 Goodwin Neck Road, Gloucester Point, Virginia. ☒

A meeting to discuss proposals from localities requesting matching grant funds from the board.

Contact: Susan M. Townsend, Program Support Technician, Department of Conservation and Recreation, P. O. Box 1024, Gloucester Point, VA 23062, telephone (804) 642-7121.

BOARD FOR CONTRACTORS

† June 29, 1994 - 9 a.m. - Open Meeting

Department of Professional and Occupational Regulation, 3600 West Broad Street, 4th Floor, Conference Room 4, Richmond, Virginia.

A regular quarterly meeting of the board to (i) address policy and procedural issues; (ii) review and render decisions on applications for contractors' licenses; (iii) and review and render case decisions on matured complaints against licensees. The meeting is open to the public; however, a portion of the board's business may be discussed in executive session.

Contact: A.R. Wade, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., 5th Floor, Richmond, VA 23230, telephone (804) 367-8585.

Recovery Fund Committee

June 22, 1994 - 9 a.m. - Open Meeting

Department of Professional and Occupational Regulation, 3600 West Broad Street, Richmond, Virginia. ☒

A meeting to consider claims filed against the Virginia Contractor Transaction Recovery Fund. This meeting will be open to the public; however, a portion of the discussion may be conducted in Executive Session. Persons desiring to participate in the meeting and requiring special accommodations or interpretive services should contact Christine Martine at (804) 367-8561. The department fully complies with the Americans with Disabilities Act. Please notify the department of your request for accommodations at least two weeks in advance for consideration of your request.

Contact: Holly Erickson, Assistant Administrator, Board for Contractors, 3600 West Broad Street, Richmond, VA 23219, telephone (804) 367-8561.

Calendar of Events

DEPARTMENT OF CORRECTIONS (STATE BOARD OF)

June 3, 1994 – Written comments may be submitted through this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Board of Corrections intends to adopt regulations entitled: **VR 230-01-005. Regulations for Public/Private Joint Venture Work Programs Operated in a State Correctional Facility.** These regulations govern the form and review process for proposed agreements between the Director of the Department of Corrections and public or private entity to operate a work program in a state correctional facility for inmates confined therein. The regulations establish both the review process and criteria for evaluating proposed agreements.

Statutory Authority: §§ 53.1-5 and 53.1-45.1 of the Code of Virginia.

Contact: Amy Miller, Regulatory Coordinator, Department of Corrections, 6900 Atmore Dr., Richmond, VA 23225, telephone (804) 674-3262.

† **June 8, 1994 - 10 a.m. – Open Meeting**
Board of Corrections, 6900 Atmore Drive, Richmond, Virginia. ☐

A meeting of the board to discuss matters as may be presented.

Contact: Vivian Toler, Secretary, Department of Corrections, 6900 Atmore Drive, Richmond, VA 23225, telephone (804) 674-3235.

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June 8, 1994 - 10 a.m. – Public Hearing
Department of Corrections, 6900 Atmore Drive, Board Room, Richmond, Virginia.

July 2, 1994 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Board of Corrections intends to amend regulations entitled: **VR 230-30-001. Minimum Standards for Jails and Lockups.** The amendments to the Minimum Standards for Jails and Lockups alter the requirements for administration and programs in jails and lockups and are based on a board committee review of the implementation and application of the standards. In summary, the changes are directed toward offering more flexibility in terms of population management; strengthening requirements where inmate supervision and general safety are a concern; and rearranging portions of the standards to enhance clarity, organization, and consistency among standards.

Statutory Authority: §§ 53.1-5, 53.1-68 and 53.1-131 of the Code of Virginia.

Contact: Lou Ann White, Department of Corrections, P. O. Box 26963, Richmond, VA 23261, telephone (804) 674-3268.

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June 8, 1994 - 10 a.m. – Public Hearing
Department of Corrections, 6900 Atmore Drive, Board Room, Richmond, Virginia.

July 2, 1994 – Written comments may be submitted until this date.

Notice is hereby given in accordance § 9-6.14:7.1 of the Code of Virginia that the State Board of Corrections intends to amend regulations entitled: **VR 230-30-002. Community Diversion Program Standards.** The amendments to the Community Diversion Program Standards alter requirements for the development, operation and evaluation of programs and services provided under the Community Diversion Incentive Act. The amendments include format and organization changes in order to enhance clarity, the deletion of some text which is now incorporated in other documents, and a few substantive changes.

Statutory Authority: §§ 53.1-5 and 53.1-182 of the Code of Virginia.

Contact: Dee Malcan, Chief of Operations, Department of Corrections, P. O. Box 26963, Richmond, VA 23261, telephone (804) 674-3242.

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July 2, 1994 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Board of Corrections intends to repeal regulations entitled: **VR 230-30-006. Jail Work/Study Release Program Standards.** The Jail Work/Study Release Program Standards are being repealed because the provisions of these regulations will be included in the proposed amended regulations, VR 230-30-001, Minimum Standards for Jails and Lockups.

Statutory Authority: §§ 53.1-5 and 53.1-131 of the Code of Virginia.

Contact: Lou Ann White, Department of Corrections, P. O. Box 26963, Richmond, VA 23261, telephone (804) 674-3268.

DEPARTMENT OF CRIMINAL JUSTICE SERVICES (CRIMINAL JUSTICE SERVICES BOARD)

June 10, 1994 - 10 a.m. – Public Hearing

Calendar of Events

State Capitol, House Room 1, Richmond, Virginia.

June 6, 1994 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Criminal Justice Services Board intends to adopt regulations entitled: **VR 240-04-4. Crime Prevention Specialists.** The purpose of the proposed regulation is to establish requirements and administrative procedures for individuals employed by local and state law-enforcement agencies who are applying for certification as a crime prevention specialist.

Statutory Authority: §§ 9-170, 9-173.14 and 9-173.15 of the Code of Virginia.

Contact: Patrick D. Harris, Manager, Department of Criminal Justice Services, 805 E. Broad St., Richmond, VA 23219, telephone (804) 786-8467.

DEPARTMENT OF EDUCATION (STATE BOARD OF)

June 7, 1994 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Board of Education intends to adopt regulations entitled: **VR 270-01-0060. Minimum Standards for the Accreditation of Child Day Programs Serving Children of Preschool Age or Younger in Public Schools.** These regulations serve as the basis for the accreditation of all nonmandated programs operated by public schools intended to serve preschool age children not subject to compulsory attendance laws.

Statutory Authority: § 22.1-19 of the Code of Virginia.

Contact: Charles W. Finley, School Accreditation Associate Specialist, Department of Education, P.O. Box 2120, Richmond, VA 23216-2120, telephone (804) 225-2747 or toll-free 1-800-292-3820.

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June 7, 1994 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Board of Education intends to adopt regulations entitled: **VR 270-01-0061. Minimum Standards for the Accreditation of Child Day Programs Serving School Age Children Offered in Public Schools.** These regulations serve as the basis for the accreditation of all nonmandated programs operated by public schools intended to serve school age children in before- and after-school programs and summer camps.

Statutory Authority: § 22.1-19 of the Code of Virginia.

Contact: Charles W. Finley, School Accreditation Associate Specialist, Department of Education, P.O. Box 2120, Richmond, VA 23216-2120, telephone (804) 225-2747 or toll-free 1-800-292-3820.

LOCAL EMERGENCY PLANNING COMMITTEE - CHESTERFIELD COUNTY

June 2, 1994 - 5:30 p.m. – Open Meeting
Chesterfield County Administration Building, 10001 Ironbridge Road, Room 502, Chesterfield, Virginia. ☎

A meeting to meet requirements of Superfund Amendment and Reauthorization Act of 1986.

Contact: Lynda G. Furr, Assistant Emergency Services Coordinator, Chesterfield Fire Department, P. O. Box 40, Chesterfield, VA 23832, telephone (804) 748-1236.

LOCAL EMERGENCY PLANNING COMMITTEE - COUNTY OF MONTGOMERY/TOWN OF BLACKSBURG

June 14, 1994 - 3 p.m. – Open Meeting
Montgomery County Courthouse, 3rd Floor, Board of Supervisors Room, Christiansburg, Virginia. ☎

A meeting to discuss the development of hazardous materials emergency response plan for Montgomery County and the Town of Blacksburg.

Contact: Steve Via, New River Valley Planning District Commission, P. O. Box 3726, Radford, VA 24143, telephone (703) 639-9313.

LOCAL EMERGENCY PLANNING COMMITTEE - WINCHESTER

June 1, 1994 - 2:30 p.m. – Open Meeting
Shawnee Fire Company, 2333 Roosevelt Boulevard, Winchester, Virginia 22601

A general meeting.

Contact: L.A. Miller, Fire Chief, Winchester Fire and Rescue Department, 126 N. Cameron St., Winchester, VA 22601, telephone (703) 662-2298.

VIRGINIA EMPLOYMENT COMMISSION

June 22, 1994 - 10:30 a.m. – Public Hearing
Virginia Employment Commission, 703 East Main Street, Richmond, Virginia.

July 15, 1994 – Written comments may be submitted through this date.

Calendar of Events

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Virginia Employment Commission intends to amend regulations entitled: **VR 300-01-1. Definitions and General Provisions.** The proposed amendment encompasses changes to public participation guidelines in response to the 1993 amendment of the Virginia Administrative Process Act and adds definitions for terms used within VEC regulations.

Statutory Authority: § 60.2-111 of the Code of Virginia.

Contact: Michael P. Maddox, Legislative Analyst, Virginia Employment Commission, P. O. Box 1358, Richmond, VA 23211, telephone (804) 786-1070.

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June 22, 1994 - 10:30 a.m. – Public Hearing
Virginia Employment Commission, 703 East Main Street, Richmond, Virginia.

July 15, 1994 – Written comments may be submitted through this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Virginia Employment Commission intends to amend regulations entitled: **VR 300-01-2. Unemployment Taxes.** The proposed amendment clarifies existing provisions to enhance ease of use.

Statutory Authority: § 60.2-111 of the Code of Virginia.

Contact: Michael P. Maddox, Legislative Analyst, Virginia Employment Commission, P. O. Box 1358, Richmond, VA 23211, telephone (804) 786-1070.

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June 22, 1994 - 10:30 a.m. – Public Hearing
Virginia Employment Commission, 703 East Main Street, Richmond, Virginia.

July 15, 1994 – Written comments may be submitted through this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Virginia Employment Commission intends to **repeal** regulations entitled: **VR 300-01-3. Benefits** and **adopt** regulations entitled: **VR 300-01-3:1. Required Records and Reports.** The purpose of the proposed amendment is to repeal current VR 300-01-3 and adopt new VR 300-01-3:1 in order to clarify and reorganize existing provisions within VEC regulations.

Statutory Authority: § 60.2-111 of the Code of Virginia.

Contact: Michael P. Maddox, Legislative Analyst, Virginia Employment Commission, P. O. Box 1358, Richmond, VA

23211, telephone (804) 786-1070.

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June 22, 1994 - 10:30 a.m. – Public Hearing
Virginia Employment Commission, 703 East Main Street, Richmond, Virginia.

July 15, 1994 – Written comments may be submitted through this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Virginia Employment Commission intends to **repeal** regulations entitled: **VR 300-01-4. Adjudication** and **adopt** regulations entitled: **VR 300-01-4:1. Combined Employer Accounts.** The purpose of the proposed amendment is to repeal current VR 300-01-4 and adopt VR 300-01-4:1 in order to clarify and reorganize existing provisions within VEC regulations.

Statutory Authority: § 60.2-111 of the Code of Virginia.

Contact: Michael P. Maddox, Legislative Analyst, Virginia Employment Commission, P. O. Box 1358, Richmond, VA 23211, telephone (804) 786-1070.

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June 22, 1994 - 10:30 a.m. – Public Hearing
Virginia Employment Commission, 703 East Main Street, Richmond, Virginia.

July 15, 1994 – Written comments may be submitted through this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Virginia Employment Commission intends to adopt regulations entitled: **VR 300-01-5. Employer Elections to Cover Multi-state Workers.** The proposed regulation would promulgate existing provisions in a new form in order to facilitate greater ease of use.

Statutory Authority: § 60.2-111 of the Code of Virginia.

Contact: Michael P. Maddox, Legislative Analyst, Virginia Employment Commission, P. O. Box 1358, Richmond, VA 23211, telephone (804) 786-1070.

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June 22, 1994 - 10:30 a.m. – Public Hearing
Virginia Employment Commission, 703 East Main Street, Richmond, Virginia.

July 15, 1994 – Written comments may be submitted through this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Virginia Employment

Commission intends to adopt regulations entitled: **VR 300-01-6. Benefits.** The proposed regulation would promulgate existing provisions in a new form in order to facilitate greater ease of use.

Statutory Authority: § 60.2-111 of the Code of Virginia.

Contact: Michael P. Maddox, Legislative Analyst, Virginia Employment Commission, P. O. Box 1358, Richmond, VA 23211, telephone (804) 786-1070.

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June 22, 1994 - 10:30 a.m. – Public Hearing

Virginia Employment Commission, 703 East Main Street, Richmond, Virginia.

July 15, 1994 – Written comments may be submitted through this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Virginia Employment Commission intends to adopt regulations entitled: **VR 300-01-7. Interstate and Multi-state Claimants.** The proposed regulation would promulgate existing provisions in a new form in order to facilitate greater ease of use.

Statutory Authority: § 60.2-111 of the Code of Virginia.

Contact: Michael P. Maddox, Legislative Analyst, Virginia Employment Commission, P. O. Box 1358, Richmond, VA 23211, telephone (804) 786-1070.

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June 22, 1994 - 10:30 a.m. – Public Hearing

Virginia Employment Commission, 703 East Main Street, Richmond, Virginia.

July 15, 1994 – Written comments may be submitted through this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Virginia Employment Commission intends to adopt regulations entitled: **VR 300-01-8. Adjudication.** The proposed regulation would promulgate existing provisions in a new form in order to facilitate greater ease of use.

Statutory Authority: § 60.2-111 of the Code of Virginia.

Contact: Michael P. Maddox, Legislative Analyst, Virginia Employment Commission, P. O. Box 1358, Richmond, VA 23211, telephone (804) 786-1070.

DEPARTMENT OF ENVIRONMENTAL QUALITY

Virginia Pollution Prevention Advisory Committee

June 2, 1994 - 1 p.m. – Open Meeting

Department of Environmental Quality, Innsbrook Corporate Center, 4900 Cox Road, Glen Allen, Virginia. ☐

A quarterly meeting. The advisory committee has been established to assist the Department of Environmental Quality in its implementation of voluntary pollution prevention technical assistance throughout the Commonwealth.

Contact: Sharon K. Baxter, Pollution Prevention Manager, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240-0009, telephone (804) 762-4344 or (804) 762-4021/TDD ☎

VIRGINIA FIRE SERVICES BOARD

† **June 23, 1994 - 7:30 p.m. – Public Hearing**

Abingdon Fire Department, 316 Park Street, Abingdon, Virginia.

A public hearing to discuss fire training and policies. The hearing is open to the public for their input and comments.

Contact: Anne J. Bales, Executive Secretary Senior, Fire Services Board, 2807 Parham Road, Suite 200, Richmond, VA 23294, telephone (804) 527-4236.

† **June 24, 1994 - 9 a.m. – Open Meeting**

Abingdon Fire Department, 316 Park Street, Abingdon, Virginia.

A business meeting to discuss training and policies. The meeting is open to the public for comments and input.

Contact: Anne J. Bales, Executive Secretary Senior, Fire Services Board, 2807 Parham Road, Suite 200, Richmond, VA 23294, telephone (804) 527-4236.

Fire/EMS Education and Training Committee

† **June 23, 1994 - 10 a.m. – Open Meeting**

Abingdon Fire Department, 316 Park Street, Abingdon, Virginia.

A meeting to discuss fire training and policies. The committee meeting is open to the public for their input and comments.

Contact: Anne J. Bales, Executive Secretary Senior, 2807 Parham Road, Suite 200, Richmond, VA 23294, telephone (804) 527-4236.

Calendar of Events

Fire Prevention and Control Committee

† June 23, 1994 - 9 a.m. - Open Meeting

Abingdon Fire Department, 316 Park Street, Abingdon, Virginia.

A meeting to discuss fire training and policies. The committee meeting is open to the public for their input and comments.

Contact: Anne J. Bales, Executive Secretary Senior, Fire Services Board, 2807 Parham Road, Suite 200, Richmond, VA 29294, telephone (804) 527-4236.

Legislative/Liaison Committee

† June 23, 1994 - 1 p.m. - Open Meeting

Abingdon Fire Department, 316 Park Street, Abingdon, Virginia.

A meeting to discuss fire training and policies. The committee meeting is open to the public for their input and comments.

Contact: Anne J. Bales, Executive Secretary Senior, Fire Services Board, 2807 Parham Road, Suite 200, Richmond, VA 23294, telephone (804) 527-4236.

BOARD OF FUNERAL DIRECTORS AND EMBALMERS

† June 13, 1994 - 11 a.m. - Open Meeting

Department of Health Professions, 6606 West Broad Street, 5th Floor, Richmond, Virginia. ☐

An examination committee meeting.

Contact: Meredyth P. Partridge, Executive Director, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9907 or (804) 662-7197/TDD ☎

BOARD OF GAME AND INLAND FISHERIES

June 10, 1994 - Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Game and Inland Fisheries intends to amend regulations entitled: **VR 325-04-2. Motorboat Numbering.** Section 58.1-3511 of the Code of Virginia requires commissioners of revenue to assess for personal property taxation purposes motorboats based on where the boats are "normally garaged, docked, or parked." Currently § 1 of this regulation requires individuals applying for a certificate of number for a motorboat to indicate on the application the "locality of principal use," not where the boats are "normally garaged, docked, or parked." Adoption of this proposed amendment to § 1 of VR 325-04-2 will enable the department to gather

the information necessary to report motorboat registration to the commissioners of revenue in conformity with § 58.1-3511.

The Soldier's and Sailor's Civil Relief Act provides certain exemptions from local personal property taxation assessment for individuals who are on active military duty. The Department of Game and Inland Fisheries does not now ask an individual to indicate military status at the time an application is submitted to register a motorboat. As a result, residents who are eligible for assessment relief are assessed personal property taxes and required to complete additional paperwork at the local level. In rectifying the problem, amending § 5 of VR 325-04-2 will enable the department to provide the commissioners of revenue needed military status information so personal property taxes will not be assessed qualifying individuals. This action will also give the Department of Game and Inland Fisheries necessary authority to require individuals to notify the agency in the event there is a change in military status.

Statutory Authority: § 29.1-701 of the Code of Virginia.

Contact: Mark D. Monson, Chief, Department of Game and Inland Fisheries, 4010 W. Broad St., Richmond, VA 23230, telephone (804) 367-1000.

BOARD FOR GEOLOGY

June 16, 1994 - 10 a.m. - Public Hearing

Department of Professional and Occupational Regulation, 3600 West Broad Street, Conference Room 395, Richmond, Virginia.

July 1, 1994 - Written comments may be submitted through this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board for Geology intends to amend regulations entitled: **VR 335-01-02. Rules and Regulations for the Virginia Board for Geology.** The purpose of the proposed amendments is to revise fee structure, allow examination fee to be adjusted in response to contracts awarded in compliance with the Virginia Public Procurement Act, and establish the status of certifications between expiration and reinstatement.

Statutory Authority: § 54.1-1402 of the Code of Virginia.

Contact: David E. Dick, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8595.

DEPARTMENT OF HEALTH (STATE BOARD OF)

† June 6, 1994 - 10 a.m. - Open Meeting

Calendar of Events

Omni Hotel, 235 Main Street, Charlottesville, Virginia. ☒
(Interpreter for the deaf provided upon request)

A work session and tour of the local health departments.

6:30 p.m. – Informal dinner.

Contact: Susan R. Rowland, Assistant to the Commissioner, Department of Health, 1500 E. Main St., Richmond, VA 23219, telephone (804) 786-3564.

† **June 7, 1994 - 9 a.m. – Open Meeting**
Omni Hotel, 235 Main Street, Charlottesville, Virginia. ☒
(Interpreter for the deaf provided upon request)

A general business meeting.

Contact: Susan R. Rowland, Assistant to the Commissioner, Department of Health, 1500 E. Main St., Richmond, VA 23219, telephone (804) 786-3564.

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June 3, 1994 - 10 a.m. – Public Hearing
Office of Emergency Medical Services, 1538 East Parham Road, Richmond, Virginia.

July 5, 1994 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Board of Health intends to adopt regulations entitled: **VR 355-32-500. Regulations Governing the Emergency Medical Services Do Not Resuscitate Program.** These regulations will replace emergency regulations previously adopted and they set forth the requirements, provisions and implementation procedures, as well as the special form, for the Emergency Medical Services Do Not Resuscitate Program.

Statutory Authority: §§ 32.1-151, 32.1-153, and 54.1-2987.1 of the Code of Virginia.

Contact: Susan McHenry, Director, Emergency Medical Services, 1538 E. Parham Road, Richmond, VA 23228, telephone (804) 371-3500 or toll-free 1-800-523-6019.

Biosolids Permit Fee Advisory Committee

† **June 9, 1994 - 10 a.m. – Open Meeting**
Department of Health, 1500 East Main Street, Room 109, Richmond, Virginia. ☒

A meeting to discuss the development of a regulation to be adopted by the Board of Health pursuant to HB 1067, setting forth a fee assessment and collection system for the issuance of permits by the State Health Commissioner to regulate the land application,

marketing or distribution of biosolids.

Contact: C.M. Sawyer, Division Director, Department of Health, Office of Water Programs, P.O. Box 2448, Richmond, VA 23218, telephone (804) 786-1755 or FAX (804) 786-5567.

VIRGINIA HEALTH SERVICES COST REVIEW COUNCIL

June 28, 1994 - 9:30 a.m. – Open Meeting
Blue Cross/Blue Shield, 2015 Staples Mill Road, Richmond, Virginia. ☒

A monthly meeting.

Contact: Kim Bolden Walker, Public Relations Coordinator, Virginia Health Services Cost Review Council, 805 E. Broad St., 6th Floor, Richmond, VA 23219, telephone (804) 786-6371.

STATE COUNCIL OF HIGHER EDUCATION FOR VIRGINIA

June 14, 1994 - 9 a.m. – Open Meeting
Radford University, Radford, Virginia.

A general business meeting. For more information and a time confirmation, contact the council.

Contact: Anne Pratt, Associate Director, 101 N. 14th Street, 9th Floor, Richmond, VA 23219, telephone (804) 225-2632 or (804) 371-8017/TDD ☎

VIRGINIA HISTORIC PRESERVATION FOUNDATION

† **June 8, 1994 - 10:30 a.m. – Open Meeting**
State Capitol, Senate Room 4, Richmond, Virginia. ☒
(Interpreter for the deaf provided upon request)

A general business meeting.

Contact: Margaret Peters, Information Director, Department of Historic Resources, 221 Governor St., Richmond, VA 23218, telephone (804) 786-3143 or (804) 786-1934/TDD ☎

DEPARTMENT OF HISTORIC RESOURCES (BOARD OF)

† **June 15, 1994 - 10 a.m. – Open Meeting**
State Capitol, Senate Room 4, Richmond, Virginia. ☒
(Interpreter for the deaf provided upon request)

A general business meeting of the board.

Contact: Margaret Peters, Information Director, Department of Historic Resources, 221 Governor St., Richmond, VA 23219, telephone (804) 786-3143 or (804)

Calendar of Events

786-1934/TDD ☎

State Review Board

† **June 14, 1994 - 10 a.m.** – Open Meeting
State Capitol, Senate Room 4, Richmond, Virginia. ☎
(Interpreter for the deaf provided upon request)

A meeting to consider the nomination of the following properties to the Virginia Landmarks Register and the National Register of Historic Places.

Loretto, Wytheville, Wythe County
Maiden Spring, Tazewell County
Mount Moriah Baptist Church and Cemetery, Roanoke (city)
Neabsco Ironworks Archaeological Site, Prince William County
La Riviere, Radford
Rose Hill, Loudoun County
Smithfield, Russell County
Springfield, Hanover County
Sunnyside, Loudoun County
Danville Historic District; consider renaming it the "Old West End Historic District"

Contact: Margaret Peters, Information Director, Department of Historic Resources, 221 Governor St., Richmond, VA 23219, telephone (804) 786-3143 or (804) 786-1934/TDD ☎

HOPEWELL INDUSTRIAL SAFETY COUNCIL

June 7, 1994 - 9 a.m. – Open Meeting
† **July 5, 1994 - 9 a.m.** – Open Meeting
† **August 2, 1994 - 9 a.m.** – Open Meeting
† **September 6, 1994 - 9 a.m.** – Open Meeting
Hopewell Community Center, Second and City Point Road, Hopewell, Virginia. ☎ (Interpreter for the deaf provided upon request)

Local Emergency Preparedness Committee Meeting on emergency preparedness as required by SARA Title III.

Contact: Robert Brown, Emergency Service Coordinator, 300 North Main Street, Hopewell, VA 23860, telephone (804) 541-2298.

BOARD OF HOUSING AND COMMUNITY DEVELOPMENT

Amusement Device Technical Advisory Committee

† **June 8, 1994 - 10 a.m.** – Open Meeting
The Jackson Center, 501 North Second Street, 2nd Floor Conference Room, Richmond, Virginia. ☎

A meeting to review and discuss regulations pertaining

to the construction, maintenance, operation and inspection of amusement devices adopted by the Board of Housing and Community Development.

Contact: Jack A. Proctor, CPCA, Deputy Director, Department of Housing and Community Development, 501 N. Second St., Richmond, VA 23219-1321, telephone (804) 371-7150 or (804) 371-7089/TDD ☎

STATEWIDE INDEPENDENT LIVING COUNCIL

† **June 7, 1994 - 10 a.m.** – Open Meeting
Department of Rehabilitative Services, 8004 Franklin Farms Drive, Richmond, Virginia. ☎ (Interpreter for the deaf provided upon request)

A regular meeting.

Contact: Kathryn A. Hayfield, Senior Planner, 8004 Franklin Farms Drive, Richmond, VA 23288, telephone (804) 662-7134, toll free 1-800-552-5019/TDD ☎ or (804) 662-9040/TDD ☎

DEPARTMENT OF LABOR AND INDUSTRY

Virginia Apprenticeship Council

† **June 2, 1994 - 10 a.m.** – Open Meeting
General Assembly Building, 910 Capitol Street, House Room C, Richmond, Virginia. ☎ (Interpreter for the deaf provided upon request)

A regular meeting to discuss and act on:

1. Report on changes of Licensed Tradesmen Certification
2. Final Report of Related Instruction Taskforce.

Contact: Robert S. Baumgardner, Director, Apprenticeship Division, Department of Labor and Industry, 13 S. 13th St., Richmond, VA 23219, telephone (804) 786-2381.

Migrant and Seasonal Farmworkers

† **June 22, 1994 - 10 a.m.** – Open Meeting
State Capitol, 910 Capitol Street, House Room 1, Richmond, Virginia. ☎ (Interpreter for the deaf provided upon request)

A regular meeting.

Contact: Marilyn Mandel, Director, Office of Planning and Policy Analysis, Department of Labor and Industry, Powers-Taylor Building, 13 S. 13th St., Richmond, VA 23219, telephone (804) 786-2385 or (804) 786-2376/TDD ☎

STATE COUNCIL ON LOCAL DEBT

June 15, 1994 - 11 a.m. - Open Meeting

July 20, 1994 - 11 a.m. - Open Meeting

James Monroe Building, 101 N. 14th Street, 3rd Floor,
Treasury Board Conference Room, Richmond, Virginia. ☒

A regular meeting subject to cancellation unless there are action items requiring the council's consideration. Persons interested in attending should call one week prior to the meeting date to ascertain whether or not the meeting is to be held as scheduled.

Contact: Gary Ometer, Debt Manager, Department of the Treasury, P. O. Box 1879, Richmond, VA 23215, telephone (804) 225-4928.

LONGWOOD COLLEGE

Community Advisory Committee

† June 13, 1994 - 4 p.m. - Open Meeting

Longwood College, Ruffner Building, Farmville, Virginia. ☒
(Interpreter for the deaf provided upon request)

A meeting to conduct routine business of the Board of Visitors.

Contact: William F. Dorrill, President, Longwood College, 201 High St., Farmville, VA 23909-1899, telephone (804) 395-2001.

STATE LOTTERY BOARD

† June 27, 1994 - 10 a.m. - Open Meeting

State Lottery Department, 2201 West Broad Street,
Richmond, Virginia. ☒ (Interpreter for the deaf provided upon request)

A regular monthly meeting. Business will be conducted according to items listed on the agenda which has not yet been determined. Two periods for public comment are scheduled.

Contact: Barbara L. Robertson, Lottery Staff Officer, State Lottery Department, 2201 W. Broad St., Richmond, VA 23220, telephone (804) 367-3106 or (804) 367-3000/TDD ☐

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (BOARD OF)

July 1, 1994 - Written comments may be submitted through this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Medical Assistance Services intends to amend regulations entitled: VR 460-03-3.1100. Amount, Duration, and

Scope of Services: Coverage Limits for Single Antigen Vaccines. The Omnibus Budget Reconciliation Act of 1993, § 13631 prohibits the payment of federal financial participation for single-antigen vaccines except where medically justified. The purpose of this proposal is to promulgate permanent regulations to provide coverage policies for single-antigen vaccines.

Prior to the current emergency regulation, DMAS' policy for the coverage of childhood immunizations provided for the payment of claims for all single- and multi-antigen vaccines at the vaccines' acquisition cost without medical justification. The exception to this policy was the coverage of the measles, mumps, and rubella (MMR) vaccine which is provided to physicians through the DMAS/Merck MMR vaccine replacement program. Prior to the emergency regulation there were no requirements that in cases where a multi-antigen vaccine was available, that medical necessity be proven to receive Medicaid reimbursement for cases in which a single-antigen vaccine was administered. With the DMAS/Merck MMR vaccine replacement program, approval by DMAS is necessary only to reimburse physicians who do not participate in the replacement program for the cost of MMR vaccine purchased by the physician for use with Medicaid children. The Merck vaccine replacement program remains unchanged by this regulation.

The Omnibus Budget Reconciliation Act of 1993 required that federal financial participation (FFP) be denied for any amount expended for a single-antigen vaccine and its administration when the use of a multi-antigen vaccine was medically appropriate. This change was effective October 1, 1993. Additionally, this requirement focused on immunizations for measles, mumps, and rubella.

The proposed regulations concerning coverage limits for single-antigen vaccines have been modified from the initial emergency regulations to reflect recently promulgated federal guidelines from the U.S. Centers for Disease Control and Prevention, at the request of the Advisory Committee on Immunization Practices (ACIP), addressing the list and schedules of pediatric vaccines to be purchased and administered under the Vaccines for Children Program. The ACIP is also required, under § 1928(c)(2)(B)(i) and 1928(e) of the Social Security Act, to establish a list of vaccines for routine administration to children, along with schedules regarding the appropriate periodicity, dosage, and contraindications. Both the list of vaccines to be purchased and the administration schedule recommend that the single-antigen Haemophilus Influenzae b Conjugate vaccine (Hib) be one of the vaccines used to immunize children against Haemophilus Influenzae type b. The ACIP also notes that the combined DTP-Hib vaccine is also available for use where appropriate.

Calendar of Events

As a result, the proposed regulations will not require physicians to use the multi-antigen DTP-Hib vaccine when immunizing Medicaid children against diphtheria, tetanus, pertussis and haemophilus influenzae b. In other words, physicians may use the single-antigen Hib vaccine and receive reimbursement without providing medical justification. Physicians may, of course, continue to use the multi-antigen DTP-Hib vaccine.

Medical justification for the use of the single-antigen measles, mumps, or rubella vaccines with Medicaid children will continue to be required. The periodicity schedule promulgated by the ACIP recommends that two doses of the multi-antigen measles, mumps, and rubella vaccine be administered at 12-15 months of age and again before school entry. The ACIP further notes that the single-antigen measles, mumps, or rubella vaccines should be used only if (i) there is a specific contraindication to one component of the MMR vaccine, (ii) the child is known to be immune or adequately vaccinated for one or more of these diseases, or (iii) there is a need to immunize a child prior to one year of age (for example, during a measles outbreak).

The advantage to Medicaid eligible children, and the intent of Congress, is for more children to be more completely immunized. There will be no significant fiscal impact associated with these proposed regulations because the incidence of use of single virus vaccines is relatively low.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Written comments may be submitted through July 1, 1994, to Michael Jurgenson, Supervisor, Division of Policy and Research, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 371-8850.

Drug Utilization Review Board

June 23, 1994 - 3 p.m. - Open Meeting

Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia.

The scheduled session is a regular meeting of the board. Routine business will be conducted.

Contact: Carol B. Pugh, Pharm.D., DUR Program Consultant, Client Services Division, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 786-3820.

BOARD OF MEDICINE

June 9, 1994 - 9 a.m. - Open Meeting

June 10, 1994 - 9 a.m. - Open Meeting

June 11, 1994 - 9 a.m. - Open Meeting

June 12, 1994 - 9 a.m. - Open Meeting

Department of Health Professions, 6606 West Broad Street, 5th Floor, Board Rooms 1, 2, 3 and 4, Richmond, Virginia.



A meeting to conduct general board business, receive committee and board reports, review reports, interview licensees, make decisions on disciplinary matters, and discuss any other items which may come before the board. The board will also review any regulations that may come before it. The board will entertain public comments during the first 15 minutes on agenda items.

Contact: Eugenia K. Dorson, Deputy Executive Director, Discipline, Board of Medicine, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9923 or (804) 662-7197/TDD ☎

Credentials Committee

June 10, 1994 - 2 p.m. - Open Meeting

June 11, 1994 - 8:15 a.m. - Open Meeting

Department of Health Professions, 6606 West Broad Street, 5th Floor, Board Room 4, Richmond, Virginia. ☒

The committee will meet in open and closed session to conduct general business, interview and review medical credentials of applicants applying for licensure in Virginia, and to discuss any other items which may come before the committee. The committee will receive public comments of those persons appearing on behalf of candidates.

Contact: Eugenia K. Dorson, Deputy Executive Director, Discipline, Board of Medicine, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9923 or (804) 662-7197/TDD ☎

Informal Conference Committee

July 6, 1994 - 9 a.m. - Open Meeting

Sheraton Inn - Roanoke Airport, Ballroom B, 2727 Ferndale Road, Roanoke, Virginia. ☒

A meeting to inquire into allegations that certain practitioners may have violated laws and regulations governing the practice of medicine and other healing arts in Virginia. The committee will meet in open and closed sessions pursuant to § 2.1-344 of the Code of Virginia. Public comment will not be received.

Contact: Karen W. Perrine, Deputy Executive Director, Discipline, Board of Medicine, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9908 or (804) 662-9943/TDD ☎

Advisory Committee on Optometry

† July 22, 1994 - 10 a.m. - Public Hearing
Department of Health Professions, 6606 West Broad Street,
5th Floor, Board Room 2, Richmond, Virginia. ☎
(Interpreter for the deaf provided upon request)

The advisory committee will hold a public hearing to receive public comments regarding amendments to VR 465-09-01, Certification for Optometrists, to include the pharmaceutical agent "Levocabastine."

Contact: Eugenia K. Dorson, Deputy Executive Director, Discipline, Department of Health Professions, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9923 or (804) 662-7197/TDD ☎

Advisory Board on Physical Therapy

June 23, 1994 - 9 a.m. - Open Meeting
Board of Medicine, 6606 West Broad Street, 5th Floor, Board Room 1, Richmond, Virginia. ☎ ☎

A meeting to receive officers and staff reports on the Federation of Physical Therapy Boards' annual meeting; review credentialing agencies relating to foreign educated therapist; discuss proposals for impaired therapist and such other business that may come before the board.

The chairman will entertain public comments following the adoption of the agenda for 10 minutes on agenda items.

Contact: Eugenia K. Dorson, Deputy Executive Director, Discipline, Board of Medicine, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9923 or (804) 662-7197/TDD ☎

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES (STATE BOARD OF)

June 22, 1994 - 10 a.m. - Open Meeting
Highlands Community Services Board, 3279 Lee Highway, Bristol, Virginia. ☎

A regular monthly meeting. Agenda to be published one week prior to meeting date. Agenda can be obtained by calling Jane Helfrich.

Tuesday: Informal Session - 8 p.m.

Wednesday: Committee Meetings - 9 a.m.

Regular Session - 10 a.m.

Contact: Jane V. Helfrich, Board Administrator, State Mental Health, Mental Retardation and Substance Abuse Services Board, P. O. Box 1797, Richmond, VA 23214,

(804) 786-3921.

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June 22, 1994 - 10 a.m. - Public Hearing
Roanoke City Hall, 215 Church Avenue, S.W., Roanoke, Virginia.

June 24, 1994 - 10 a.m. - Public Hearing
Fairfax County Government Center, Fairfax County Board Auditorium, 12000 Government Center Parkway, Fairfax, Virginia.

June 27, 1994 - 10 a.m. - Public Hearing
Henrico Area Mental Health and Retardation Services Board, 10299 Woodman Road, Conference Room C, Glen Allen, Virginia.

July 6, 1994 - 10 a.m. - Public Hearing
Eastern Virginia Medical School, Lewis Hall Auditorium, 700 Olney Road, Norfolk, Virginia.

August 16, 1994 - Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Mental Health, Mental Retardation and Substance Abuse Services Board intends to repeal regulations entitled: VR 470-02-03. Rules and Regulations for the Licensure of Private Psychiatric Hospitals; VR 470-02-07. Rules and Regulations for the Licensure of Correctional Psychiatric Facilities; VR 470-02-08. Rules and Regulations for the Licensure of Supported Residential Programs and Residential Respite Care/Emergency Services Facilities; VR 470-02-09. Rules and Regulations for the Licensure of Outpatient Facilities; VR 470-02-10. Rules and Regulations for the Licensure of Day Support Programs; and VR 470-02-11. Rules and Regulations for the Licensure of Residential Facilities and adopt regulations entitled: VR 470-02-13. Regulations for the Licensure of Facilities and Providers of Mental Health, Mental Retardation and Substance Abuse Services. The purpose of these regulatory actions is to redraft and consolidate six current licensure regulations for all licensable facilities except residential facilities for children.

Statutory Authority: § 37.1-10(6) and Chapter 8 (§ 37.1-179 et s eq.) of Title 37.1 of the Code of Virginia.

Written comments may be submitted until August 16, 1994, to Jacqueline M. Ennis, Assistant Commissioner, Department of Mental Health, Mental Retardation and Substance Abuse Services, P. O. Box 1797, Richmond, VA 23214.

Contact: Edith Smith, Manager, Licensure Operations, Department of Mental Health, Mental Retardation and Substance Abuse Services, P. O. Box 1797, Richmond, VA

Calendar of Events

23214, telephone (804) 371-6885.

State Human Rights Committee

† **June 3, 1994 - 9 a.m.** — Open Meeting
Southwestern Virginia Mental Health Institute, Auditorium,
502 East Main Street, Marion, Virginia. ☒

A meeting to discuss human rights issues involving local human rights committees, including but not limited to DMHMRSAS Licensed MH, MR, and SAS programs.

Contact: Elsie D. Little, Director of Human Rights, Department of Mental Health, Mental Retardation and Substance Abuse Services, 109 Governor St., P.O. Box 1797, Richmond, VA 23214, telephone (804) 786-3988.

Part H Interagency Management Team

† **June 10, 1994 - 10:30 a.m.** — Open Meeting
James Madison Building, 109 Governor Street, 10th Floor
Conference Room, Richmond, Virginia. ☒

A monthly meeting of the management team to address issues important to the implementation of a comprehensive system of early intervention services for infants and toddlers with disabilities and their families.

Contact: Kyla Patterson, Part H Administrative Consultant, Department of Mental Health, Mental Retardation and Substance Abuse Services, P. O. Box 1797, Richmond, VA 23214, telephone (804) 786-3710.

STATE MILK COMMISSION

† **June 15, 1994 - 10:30 a.m.** — Open Meeting
State Milk Commission, 200 North Ninth Street, Suite 1015,
Richmond, Virginia. (Interpreter for the deaf provided upon request)

A regular meeting to discuss industry issues, distributor licensing, Virginia base transfers, Virginia baseholding license amendments, regulations, fiscal matters, and to receive reports from staff of the Milk Commission. Additionally, the commission will review a request to consider amending Regulation No. 10, paragraph 7(G)(2) of the Rules and Regulations for the Control, Regulation and Supervision of the Milk Industry in Virginia. The commission may consider other matters pertaining to its responsibilities. Any persons who require accommodations in order to participate at this meeting should contact the agency at least five days prior to the meeting date so that suitable arrangements can be made for many appropriate accommodations.

Contact: Edward C. Wilson, Jr., Deputy Administrator, State Milk Commission, 200 N. Ninth St., Suite 1015,

Richmond, VA 23219-3414, telephone (804) 786-2013/TDD ☒

BOARD OF NURSING

† **June 3, 1994 - 9 a.m.** — Open Meeting
† **June 6, 1994 - 9 a.m.** — Open Meeting
† **June 9, 1994 - 9 a.m.** — Open Meeting
Department of Health Professions, 6606 West Broad Street,
5th Floor, Conference Room 4, Richmond, Virginia. ☒
(Interpreter for the deaf provided upon request)

A Special Conference Committee, comprised of two members of the Virginia Board of Nursing, will conduct informal conferences with licensees to determine what, if any, action should be recommended to the Board of Nursing. Public comment will not be received.

Contact: M. Teresa Mullin, R.N., Assistant Executive Director, Board of Nursing, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9909 or (804) 662-7197/TDD ☒

Education Conference Committee

† **June 22, 1994 - Noon** — Open Meeting
Department of Health Professions, 6606 West Broad Street,
5th Floor, Conference Room 3, Richmond, Virginia. ☒
(Interpreter for the deaf provided upon request)

The Education Conference Committee will meet to consider matters related to nursing education programs approved by the Board of Nursing and make recommendations to the board as needed.

The committee will conduct an informational proceeding during the meeting from 2 p.m. to 4 p.m. to hear comments related to the impact of health care reform on nursing education with regard to the shifting of student learning experiences to the community and faculty supervision of students in these settings.

Contact: Corinne F. Dorsey, R.N., Executive Director, Board of Nursing, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9909 or (804) 662-7197/TDD ☒

Nurse Aide Registry

† **June 13, 1994 - 8:30 a.m.** — Open Meeting
† **June 14, 1994 - 8:30 a.m.** — Open Meeting
Virginia Employment Commission, 870 East Main Street,
Wytheville Shopping Plaza, Wytheville, Virginia. ☒
(Interpreter for the deaf provided upon request)

† **June 17, 1994 - 8 a.m.** — Open Meeting
Radisson Hotel Lynchburg, Poplar Forest Room, 601 Main Street, Lynchburg, Virginia. ☒ (Interpreter for the deaf

provided upon request)

A Special Conference Committee, comprised of two members of the Virginia Board of Nursing, will conduct informal conferences with nurse aides to determine what, if any, action should be recommended to the Board of Nursing. Public comment will not be received.

Contact: Nancy K. Durrett, R.N., M.S.N., Assistant Executive Director, Board of Nursing, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9909 or (804) 662-7197/TDD ☎

BOARD OF OPTOMETRY

† **June 1, 1994 - 9 a.m.** – Open Meeting
Department of Health Professions, 6606 West Broad Street, 4th Floor, Richmond, Virginia. ☎ (Interpreter for the deaf provided upon request)

Informal conferences. Brief public comment will be received at the beginning of the conference.

Contact: Carol Stamey, Administrative Assistant, Board of Optometry, 6606 W. Broad St., 4th Floor, Richmond, VA 23230-1717, telephone (804) 662-9910 or (804) 662-7197/TDD ☎

BOARD OF PROFESSIONAL COUNSELORS

† **June 16, 1994 - 5 p.m.** – Open Meeting
Embassy Suites, 2925 Emerywood Parkway, Richmond, Virginia. ☎

A meeting of the Executive Committee of the Board of Professional Counselors to consider credentials and correspondence regarding credentials. Public comments will not be received.

Contact: Evelyn B. Brown, Executive Director or Joyce D. Williams, Administrative Assistant, Department of Health Professions, 6606 W. Broad St., Richmond, VA 23230, telephone (804) 662-9912.

† **June 17, 1994 - 9 a.m.** – Open Meeting
Department of Health Professions, 6606 West Broad Street, Conference Room 3, Richmond, Virginia. ☎

A regular meeting to consider committee reports, act on correspondence and any other matters under the jurisdiction of the board, and conduct regulatory review. This is a public meeting and there will be a 15-minute public comment period from 1 p.m. to 1:15 p.m.

Contact: Evelyn B. Brown, Executive Director or Joyce D. Williams, Administrative Assistant, Board of Professional Counselors, 6606 W. Broad St., 4th Floor, Richmond, VA

23230, telephone (804) 662-9912.

PROTECTION AND ADVOCACY FOR INDIVIDUALS WITH MENTAL ILLNESS ADVISORY COUNCIL

† **June 16, 1994 - 9 a.m.** – Open Meeting
Shoney's Inn, Conference Room, 7007 West Broad Street, Richmond, Virginia. ☎ (Interpreter for the deaf provided upon request)

A regular bimonthly meeting. Time is provided for public comment at the beginning of the meeting.

Contact: Kenneth Shores, Department for Rights of Virginians with Disabilities, Monroe Building, 101 N. 14th St., 17th Floor, Richmond, VA 23219, telephone (804) 225-2042/TDD ☎

VIRGINIA PUBLIC TELECOMMUNICATIONS BOARD

† **June 9, 1994 - 10 a.m.** – Open Meeting
Radisson Hotel, 555 East Canal Street, Richmond, Virginia.

A quarterly meeting. Agenda items include approval of contracts and grants allocations for 94-95, legislative updates, NTIA grant application and other items of interest.

Contact: Charlean Murray, Executive Secretary Senior, Department of Information Technology, 110 S. 7th St., 1st Floor, Richmond, VA 23219.

REAL ESTATE APPRAISER BOARD

June 7, 1994 - 10 a.m. – Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, Richmond, Virginia.

A general business meeting.

Contact: Karen W. O'Neal, Assistant Director, Real Estate Appraiser Board, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-2039.

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June 21, 1994 - 10 a.m. – Public Hearing
Department of Professional and Occupational Regulation, 3600 West Broad Street, 4th Floor, Richmond, Virginia.

July 18, 1994 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Real Estate Appraiser Board intends to amend regulations entitled: **VR 583-01-03. Real Estate Appraiser Board Rules and**

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Regulations. The purpose of the proposed amendments is to achieve consistency with current federal standards and guidelines, allow for a renewal grace period, permit reinstatement, reflect current board policy, and improve current continuing education requirements.

Statutory Authority: §§ 54.1-2013, 54.1-2014, and 54.1-2016 of the Code of Virginia.

Contact: Karen W. O'Neal, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-0500.

REAL ESTATE BOARD

† **June 6, 1994 - 10 a.m. – Open Meeting**
Fredericksburg Juvenile and Domestic Relations District Court, 701 Princess Anne Street, Fredericksburg, Virginia.

A formal hearing in regard to Real Estate Board v. Edward T. Shoup, File Number 92-02214.

Contact: Stacie G. Camden, Legal Assistant, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-2393.

Time-Share Advisory Committee

† **June 20, 1994 - 10 a.m. – Open Meeting**
Department of Professional and Occupational Regulation, 3600 W. Broad Street, Richmond, Virginia. ☒ (Interpreter for the deaf provided upon request)

The Time-Share Advisory Committee will review the registration and disclosure requirements of the Virginia Real Estate Time-Share Regulations. Changes made necessary by statutory amendments effective July 1, 1994, will be discussed.

Contact: Emily O. Wingfield, Property Registration Administrator, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8510 or (804) 367-9753/TDD ☎

BOARD OF REHABILITATIVE SERVICES

† **June 23, 1994 - 10 a.m. – Open Meeting**
Department of Rehabilitative Services, 8004 Franklin Farms Drive, Richmond, Virginia.

A meeting to conduct regular monthly business of the board.

Contact: Susan L. Urofsky, Commissioner, Department of Rehabilitative Services, 8004 Franklin Farms Drive, Richmond, VA 23230, telephone (804) 662-7010, toll free 1-800-552-5019/TDD and Voice, or (804) 662-9040/TDD ☎

VIRGINIA RESOURCES AUTHORITY

† **June 14, 1994 - 9:30 a.m. – Open Meeting**
Ramada Inn Ocean Tower Resort, 57th and Oceanview, Virginia Beach, Virginia.

The board will meet to approve minutes of the meeting of May 10, 1994; to review the authority's operations for the prior months; and to consider other matters and take other actions as it may deem appropriate. The planned agenda of the meeting will be available at the offices of the authority one week prior to the date of the meeting. Public comments will be received at the beginning of the meeting.

Contact: Shockley D. Gardner, Jr., Virginia Resources Authority, 909 E. Main St., Suite 607, Mutual Building, Richmond, VA 23219, telephone (804) 644-3100 or FAX (804) 644-3109.

† **July 12, 1994 - 9:30 a.m. – Open Meeting**
Virginia Resources Authority, The Mutual Building, 909 East Main Street, Board Room, Suite 607, Richmond, Virginia.

The board will meet to approve minutes of the meeting of June 14, 1994; to review the authority's operations for the prior months and to consider other matters and take other actions as it may deem appropriate. The planned agenda of the meeting will be available at the offices of the authority one week prior to the date of the meeting. Public comments will be received at the beginning of the meeting.

Contact: Shockley D. Gardner, Jr., Virginia Resources Authority, 909 E. Main St., Suite 607, Richmond, VA 23219, telephone (804) 644-3100 or FAX (804) 644-3109.

† **August 9, 1994 - 9:30 a.m. – Open Meeting**
Virginia Resources Authority, The Mutual Building, 909 East Main Street, Board Room, Suite 607, Richmond, Virginia.

The board will meet to approve minutes of the meeting of July 12, 1994; to review the authority's operations for the prior months and to consider other matters and take other actions as it may deem appropriate. The planned agenda of the meeting will be available at the offices of the authority one week prior to the date of the meeting. Public comments will be received at the beginning of the meeting.

Contact: Shockley D. Gardner, Jr., Virginia Resources Authority, 909 E. Main St., Suite 607, Richmond, VA 23219, telephone (804) 644-3100 or FAX (804) 644-3109.

SEWAGE HANDLING AND DISPOSAL APPEALS REVIEW BOARD

† **June 29, 1994 - 10 a.m. – Open Meeting**

Calendar of Events

County of Henrico, Administrative Building, Board of Supervisors Board Room, 4301 East Parham Road, Richmond, Virginia. ☎

† **August 10, 1994 - 10 a.m.** — Open Meeting
General Assembly Building, 910 Capitol Street, Senate Room A, Richmond, Virginia. ☎

A meeting to hear all administrative appeals of denials of onsite sewage disposal systems permits pursuant to §§ 32.1-166.1 et seq. and 9-6.14:12 of the Code of Virginia and VR 355-34-02.

Contact: Constance G. Talbert, Secretary to the Board, 1500 E. Main St., P.O. Box 2448, Suite 117, Richmond, VA 23218, telephone (804) 786-1750.

DEPARTMENT OF SOCIAL SERVICES (STATE BOARD OF)

† **June 15, 1994 - 1:30 p.m.** — Open Meeting
† **June 16, 1994 - 9 a.m.** — Open Meeting (if necessary)

† **July 20, 1994 - 1:30 p.m.** — Open Meeting
† **July 21, 1994 - 9 a.m.** — Open Meeting (if necessary)
Department of Social Services, 730 East Broad Street, Richmond, Virginia. ☎

A work session and formal business meeting.

Contact: Phyllis Sisk, Special Assistant to the Commissioner, Department of Social Services, 730 E. Broad St., Richmond, VA 23219, telephone (804) 692-1900, toll free 1-800-552-3431 or 1-800-552-7096/TDD ☎

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June 17, 1994 — Written comments may be submitted through this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Board of Social Services intends to amend regulations entitled: **VR 615-25-01:1. Minimum Standards for Licensed Family Day Homes.** The purpose of the regulation is to clarify or revise certain existing licensing requirements to ensure the reasonableness and enforceability of these standards while safeguarding protection to children in care.

Statutory Authority: §§ 63.1-196 and 63.1-202 of the Code of Virginia.

Written comments may be submitted through June 17, 1994, to Alfreda Redd, Department of Social Services, Division of Licensing Programs, 730 East Broad Street, 7th Floor, Richmond, Virginia 23219.

Contact: Peggy Friedenbergy, Legislative Analyst, Department of Social Services, Office of Governmental

Affairs, 730 E. Broad St., 8th Floor, Richmond, VA 23219, telephone (804) 692-1820.

SPECIALIZED TRANSPORTATION COUNCIL

† **June 15, 1994 - 10 a.m.** — Open Meeting
Northern Virginia Planning District Commission, 7535 Little River Turnpike, Suite 100, Annandale, Virginia. ☎
(Interpreter for the deaf provided upon request)

A general business meeting. Public comments are welcome from 11 a.m. until noon.

Contact: Bob Knox, Assistant to the Commissioner, Department for the Aging, 700 East Franklin Street, 10th Floor, Richmond, VA 23219, telephone (804) 225-3140, toll free 1-800-552-3402 or (804) 225-2271/TDD ☎

TRANSPORTATION SAFETY BOARD

June 6, 1994 - 9:30 a.m. — Open Meeting
Department of Motor Vehicles, 2300 West Broad Street, Room 702, Richmond, Virginia. ☎

A quarterly meeting to discuss new transportation safety legislation.

Contact: Bill Dennis, Executive Assistant, Department of Motor Vehicles, 2300 W. Broad St., Richmond, VA 23220, telephone (804) 367-2666.

DEPARTMENT OF TRANSPORTATION (COMMONWEALTH TRANSPORTATION BOARD)

June 9, 1994 - 2 p.m. — Public Hearing
Department of Transportation, 1221 East Broad Street, Auditorium, Richmond, Virginia. ☎ (Interpreter for the deaf provided upon request)

Final allocation hearing for the eastern districts. Final hearing to receive comments on highway allocations for the upcoming year, and on updating the Six-Year Improvement Program for the interstate, primary, and urban systems, as well as mass transit for the Richmond, Fredericksburg, Suffolk, Culpeper and Northern Virginia districts.

Contact: Claude D. Garver, Jr., Assistant Commissioner of Programming and Planning, Department of Transportation, 1401 E. Broad St., Richmond, VA 23219, telephone (804) 786-1476 or (804) 786-4410/TDD ☎

June 9, 1994 - 9 a.m. — Public Hearing
Salem District Office, Harrison Avenue, Salem, Virginia. ☎
(Interpreter for the deaf provided upon request)

Final allocation hearing for the western districts. Final hearing to receive comments on highway allocations

Calendar of Events

for the upcoming year, and on updating the Six-Year Improvement Program for the interstate, primary, and urban systems, as well as mass transit for Bristol, Salem, Lynchburg and Staunton districts.

Contact: Claude D. Garver, Jr., Assistant Commissioner of Programming and Planning, Department of Transportation, 1401 E. Broad St., Richmond, VA 23219, telephone (804) 786-1476 or (804) 786-4410/TDD ☎

TREASURY BOARD

June 15, 1994 - 9 a.m. - Open Meeting

July 20, 1994 - 9 a.m. - Open Meeting

James Monroe Building, 101 N. 14th Street, Treasury Board Room, 3rd Floor, Richmond, Virginia. ☎

A regular meeting.

Contact: Gloria J. Hatchel, Administrative Assistant to the Treasurer, Department of the Treasury, 101 N. 14th St., 3rd Floor, Richmond, VA 23219, telephone (804) 371-6011.

VIRGINIA VETERANS CARE CENTER

Board of Trustees

† **June 4, 1994 - 11 a.m. - Open Meeting**

Virginia Veterans Care Center, 4550 Shenandoah Avenue, Roanoke, Virginia. ☎

A meeting to review the operations of the Virginia Veterans Care Center.

Contact: John T. Plichta, Executive Director, Virginia Veterans Care Center, P.O. Box 6334, Roanoke, VA 24017, telephone (703) 857-6974, toll free 1-800-220-8387 or (703) 342-8810/TDD ☎

VIRGINIA VOLUNTARY FORMULARY BOARD

July 21, 1994 - 10:30 a.m. - Open Meeting

Washington Building, 1100 Bank Street, 2nd Floor Board Room, Richmond, Virginia.

A meeting to consider public hearing comments and review new product data for products pertaining to the Virginia Voluntary Formulary.

Contact: James K. Thomson, Director, Bureau of Pharmacy Services, 109 Governor St., Room B1-9, Richmond, VA 23219, telephone (804) 786-4326.

VIRGINIA WAR MEMORIAL FOUNDATION

† **June 27, 1994 - Noon - Open Meeting**

Virginia War Memorial, 621 South Belvidere Street,

Richmond, Virginia. ☎ (Interpreter for the deaf provided upon request)

A regular business meeting.

Contact: Jon C. Hatfield, Acting Deputy Director, Division of Engineering and Buildings, Department of General Services, 805 E. Broad St., Room 101, Richmond, VA 23219, telephone (804) 786-3263 or (804) 786-6152/TDD ☎

BOARD FOR WASTE MANAGEMENT FACILITY OPERATORS

† **July 21, 1994 - 8:30 a.m. - Open Meeting**

Department of Professional and Occupational Regulation, 3600 West Broad Street, Conference Room 4A, Richmond, Virginia. ☎

A general meeting.

Contact: David E. Dick, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8595 or (804) 367-9753/TDD ☎

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June 10, 1994 - 10 a.m. - Public Hearing

Department of Professional and Occupational Regulation, 3600 West Broad Street, Conference Room 395, Richmond, Virginia.

July 1, 1994 - Written comments may be submitted through 5 p.m. on this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board for Waste Management Facility Operators intends to amend regulations entitled: **VR 674-01-02. Waste Management Facility Operators Licensing Regulations.** The proposed revisions increase the fees charged to applicants to comply with § 54.1-113 of the Code of Virginia; revise definitions; empower the board to extend interim certifications for up to six months should training and examination resources be inadequate to allow industry compliance by January 1, 1995; delete the first time full certification renewal continuing professional education (CPE) requirement as too rigorous just two years after meeting the entry training and examination requirements; revise the language describing the required examinations to recognize a change in the manner in which examinations will be constructed and administered; delete the 70% examination passing score in favor of a psychometrically established passing score; establish the status of a certified individual between the date his certification expires and the date it is reinstated to add a provision on which the current regulations are silent; and revise language to add to clarity, and correct errors in citations, grammar and word usage.

Statutory Authority: § 54.1-2211 of the Code of Virginia.

Contact: David E. Dick, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8595.

CHRONOLOGICAL LIST

OPEN MEETINGS

June 1

Emergency Planning Committee, Local - Winchester
† Optometry, Board of

June 2

† Chesapeake Bay Local Assistance Board
Emergency Planning Committee, Local - Chesterfield County
Environmental Quality, Department of
- Pollution Prevention Advisory Committee, Virginia
† Labor and Industry, Department of
- Apprenticeship Council, Virginia

June 3

† Mental Health, Mental Retardation and Substance Abuse Services, Department of
- State Human Rights Committee
† Nursing, Board of

June 4

† Veterans Care Center, Virginia
- Board of Trustees

June 6

Barbers, Board for
† Health, State Board of
† Nursing, Board of
† Real Estate Board
Transportation Safety Board

June 7

Auctioneers Board, Virginia
Hopewell Industrial Safety Council
Real Estate Appraiser Board
† Health, State Board of
† Independent Living Council, Statewide

June 8

Conservation and Development of Public Beaches, Board on
† Corrections, Board of
† Historic Preservation Foundation, Virginia
† Housing and Community Development, Board of
- Amusement Device Technical Advisory Committee

June 9

Chesapeake Bay Local Assistance Board

- Northern Area Review Committee
† Child Day-Care Council
† Health, Department of
- Biosolids Permit Fee Advisory Committee
Medicine, Board of
† Nursing, Board of
† Telecommunications Board, Virginia Public

June 10

† Mental Health, Mental Retardation and Substance Abuse Services, Department of
- Part H Interagency Management Team
Medicine, Board of
- Credentials Committee

June 11

Medicine, Board of

June 12

Medicine, Board of

June 13

† Asbestos Licensing Board, Virginia
† Funeral Directors and Embalmers, Board of
† Longwood College
- Community Advisory Committee
† Nursing, Board of
- Nurse Aide Registry

June 14

Agriculture and Consumer Services, Department of
- Virginia Marine Products Board
Higher Education for Virginia, State Council of
Emergency Planning Committee, Local - County of Montgomery/Town of Blacksburg
† Historic Resources, Department of
- State Review Board
† Nursing, Board of
- Nurse Aide Registry
† Resources Authority, Virginia

June 15

† Historic Resources Board, Virginia
† Labor and Industry, Department of
- Migrant and Seasonal Farmworkers
Local Debt, State Council on
† Milk Commission, State
† Social Services, State Board of
† Specialized Transportation Council
Treasury Board

June 16

Chesapeake Bay Local Assistance Board
- Central Area Review Committee
† Individuals with Mental Illness Advisory Council, Protection and Advocacy for
† Professional Counselors, Board of
† Social Services, State Board of

June 17

Calendar of Events

- † Nursing, Board of
- Nurse Aide Registry
- † Professional Counselors, Board of

June 20

- † Real Estate Board
- Time-Share Advisory Committee

June 22

- Contractors, Board for
- Recovery Fund Committee
- Chesapeake Bay Local Assistance Board
- Southern Area Review Committee
- Mental Health, Mental Retardation and Substance Abuse Services Board, State
- † Nursing, Board of
- Education Conference Committee

June 23

- † Fire Services Board, Virginia
- Fire/EMS Education and Training Committee
- Fire Prevention and Control Committee
- Legislative/Liaison Committee
- Medical Assistance Services, Department of
- Drug Utilization Review Board
- Medicine, Board of
- Physical Therapy, Advisory Board on
- † Rehabilitative Services, Board of

June 24

- Agriculture and Consumer Services, Department of
- Virginia Egg Board
- † Fire Services Board, Virginia

June 27

- † Lottery Department, State
- † War Memorial Foundation, Virginia

June 28

- Agriculture and Consumer Services, Department of
- Pesticide Control Board
- Health Services Cost Review Council, Virginia

June 29

- † Contractors, State Board for
- † Sewage Handling and Disposal Appeals Review Board

July 5

- † Agriculture and Consumer Services, Department of
- Virginia Winegrowers Advisory Board
- † Hopewell Industrial Safety Council

July 6

- Medicine, Board of
- Informal Conference Committee

July 12

- † Resources Authority, Virginia

July 20

- Local Debt, State Council on
- † Social Services, State Board of
- Treasury Board

July 21

- † Social Services, State Board of
- Voluntary Formulary Board, Virginia
- † Waste Management Facility Operators, Board for

August 2

- † Hopewell Industrial Safety Council

August 9

- † Resources Authority, Virginia

August 10

- † Sewage Handling and Disposal Appeals Review Board

September 6

- † Hopewell Industrial Safety Council

PUBLIC HEARINGS

June 3

- Health, Board of

June 8

- Corrections, Board of

June 9

- Transportation, Department of

June 10

- Criminal Justice Services, Department of
- Waste Management Facility Operators, Board for

June 16

- Geology, Board for

June 21

- Real Estate Appraiser Board

June 22

- Employment Commission, Virginia
- Mental Health, Mental Retardation and Substance Abuse Services, Department of

June 23

- † Fire Services Board, Virginia

June 24

- Mental Health, Mental Retardation and Substance Abuse Services, Department of

June 27

- Mental Health, Mental Retardation and Substance Abuse Services, Department of

July 6

Mental Health, Mental Retardation and Substance
Abuse Services, Department of

July 22

† Medicine, Board of
- Advisory Committee on Optometry

Calendar of Events
